



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 431 and 457

[CMS-6068-P]

RIN 0938-AS74

Medicaid/CHIP Program; Medicaid Program and Children's Health Insurance Program (CHIP); Changes to the Medicaid Eligibility Quality Control and Payment Error Rate Measurement Programs in Response to the Affordable Care Act

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would update the Medicaid Eligibility Quality Control (MEQC) and Payment Error Rate Measurement (PERM) programs based on the changes to Medicaid and the Children's Health Insurance Program (CHIP) eligibility under the Patient Protection and Affordable Care Act. This proposed rule would also implement various other improvements to the PERM program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on [Insert date 60 days after date of publication in the **Federal Register**].

ADDRESSES: In commenting, please refer to file code CMS-6068-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the instructions under the "More Search Options" tab.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-6068-P,

P.O. Box 8016,

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-6068-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

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Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, please call (410) 786-7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Bridgett Rider, (410) 786-2602

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view

public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1-800-743-3951.

Acronyms

AFR	Agency Financial Report
AT	Account Transfer file
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare and Medicaid Services
DAB	Departmental Appeals Board
DHHS	Department of Health and Human Services
DP	Data Processing
ELA	Express Lane Agency
ELE	Express Lane Eligibility
EOB	Explanation of Benefits
ERC	Eligibility Review Contractor
FFM	Federally Facilitated Marketplace
FFM-A	Federally Facilitated Marketplace-Assessment
FFM-D	Federally Facilitated Marketplace-Determination
FFP	Federal Financial Participation

FFS	Fee-For-Service
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentages
FY	Fiscal Year
HHS	Health and Human Services
HIPP	Health Insurance Premium Payments
IFC	Interim Final Rule with Comment period
IPERA	Improper Payments Elimination and Recovery Act
IPERIA	Improper Payments Elimination and Recovery Improvement Act
IPIA	Improper Payments Information Act
IRFA	Initial Regulatory Flexibility Analysis
MAGI	Modified Adjusted Gross Income
MEQC	Medicaid Eligibility Quality Control
MSO	Medicaid State Operations
OMB	Office of Management and Budget
PCCM	Primary Care Case Management
PERM	Payment Error Rate Measurement
RC	Review Contractor
RFA	Regulatory Flexibility Act
RIA	Regulatory Impact Analysis
SC	Statistical Contractor
SHO	State Health Official
the Act	Social Security Act
UMRA	Unfunded Mandates Reform Act

I. Background

A. Introduction

The Medicaid Eligibility Quality Control (MEQC) program at §431.810 through §431.822 implements section 1903(u) of the Social Security Act (the Act) and requires states to report to the Secretary the ratio of states' erroneous excess payments for medical assistance under the state plan to total expenditures for medical assistance. Section 1903(u) of the Act sets a 3 percent threshold for eligibility-related improper payments in any fiscal year (FY) and generally requires the Secretary to withhold payments to states with respect to the amount of improper payments that exceed the threshold. The Act requires states to provide information, as specified by the Secretary, to determine whether they have exceeded this threshold.

The Payment Error Rate Measurement (PERM) program was developed to implement the requirements of the Improper Payments Information Act (IPIA) of 2002 (Pub. L. 107–300), which requires the heads of federal agencies to review all programs and activities that they administer to determine and identify any programs that are susceptible to significant erroneous payments. If programs are found to be susceptible to significant improper payments, then the agency must estimate the annual amount of erroneous payments, report those estimates to the Congress, and submit a report on actions the agency is taking to reduce improper payments. IPIA was amended by Improper Payments Elimination and Recovery Act of 2010 (IPERA) (Pub. L. 111–204) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA) (Pub. L. 112-248).

The IPIA directed OMB to provide guidance on implementation; OMB provides such guidance for IPIA, IPERA, and IPERIA in OMB circular A-123 App. C. OMB defines “significant improper payments” as annual erroneous payments in the program exceeding (1) both \$10 million and 1.5 percent of program payments, or (2) \$100 million regardless of

percentage (OMB M–15-02, OMB Circular A–123, App. C October 20, 2014). Erroneous payments and improper payments have the same meaning under OMB guidance. For those programs found to be susceptible to significant erroneous payments, federal agencies must provide the estimated amount of improper payments and report on what actions the agency is taking to reduce those improper payments, including setting targets for future erroneous payment levels and a timeline by which the targets will be reached. Section 2(b)(1) of IPERA clarified that, when meeting IPIA and IPERA requirements, agencies must produce a statistically valid estimate, or an estimate that is otherwise appropriate using a methodology approved by the Director of the Office of Management and Budget (OMB). IPERIA further clarified requirements for agency reporting on actions to reduce improper payments and recover improper payments.

The Medicaid program and the Children’s Health Insurance Program (CHIP) were identified as at risk for significant erroneous payments. As set forth in OMB Circular A-136, Financial Reporting Requirements, for IPIA reporting, the Department of Health and Human Services (DHHS) reports the estimated improper payment rates (and other required information) for both programs in its annual Agency Financial Report (AFR).

The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (Pub. L. 111–3) was enacted on February 4, 2009. Sections 203 and 601 of the CHIPRA relate to the PERM program. Section 203 of the CHIPRA amended sections 1902(e)(13) and 2107(e)(1) of the Act to establish a state option for an express lane eligibility (ELE) process for determining eligibility for children and an error rate measurement for the enrollment of children under the ELE option. ELE provides states with important new avenues to expeditiously facilitate children’s Medicaid or CHIP enrollment through a fast and simplified eligibility determination or renewal process by which states may rely on findings made by another program designated as an

express lane agency (ELA) for eligibility factors including, but not limited to, income or household size. Section 1902(e)(13)(E) of the Act, as amended by the CHIPRA, specifically addresses error rates for ELE. States are required to conduct a separate analysis of ELE error rates, applying a 3 percent error rate threshold, and are directed not to include those children who are enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an ELA in any data or samples used for purposes of complying with a MEQC review or as part of the PERM measurement. Section 203(b) of the CHIPRA directed the Secretary to conduct an independent evaluation of children who enrolled in Medicaid or CHIP plans through the ELE option to determine the percentage of children who were erroneously enrolled in such plans, the effectiveness of the option, and possible legislative or administrative recommendations to more effectively enroll children through reliance on such findings.

Section 601(a)(1) of the CHIPRA amended section 2015(c) of the Act, and provided a 90 percent federal match for CHIP spending related to PERM administration and excluded such spending from the CHIP 10 percent administrative cap. (Section 2105(c)(2) of the Act generally limits states to using no more than 10 percent of the CHIP benefit expenditures for administrative costs, outreach efforts, additional services other than the standard benefit package for low-income children, and administrative costs.)

Section 601(b) of the CHIPRA required that the Secretary issue a new PERM rule and delay any calculations of a PERM improper payment rate for CHIP until 6 months after the new PERM final rule was effective. Section 601(c) of the CHIPRA established certain standards for such a rule, and section 601(d) of the CHIPRA provided that states that were scheduled for PERM measurement in FY 2007 could elect to accept a CHIP PERM improper payment rate determined in whole or in part on the basis of data for FY 2007, or could elect instead to consider its PERM measurement conducted for FY 2010 as the first fiscal year for which PERM applies

to the state for CHIP. This same section provided that states that were scheduled for PERM measurement in FY 2008 could elect to accept a CHIP PERM improper payment rate determined in whole or in part on the basis of data for FY 2008, or could elect instead to consider its PERM measurement conducted for FY 2010 or FY 2011 as the first fiscal year for which PERM applies to the state for CHIP. The new PERM rule required by the CHIPRA was to include the following:

- Clearly defined criteria for errors for both states and providers.
- Clearly defined processes for appealing error determinations.
- Clearly defined responsibilities and deadlines for states in implementing any corrective action plans (CAPs).
- Requirements for state verification of an applicant's self-declaration or self-certification of eligibility for, and correct amount of, medical assistance under Medicaid or child health assistance under CHIP.
- State-specific sample sizes for application of the PERM requirements.

The Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) (collectively referred to as the Affordable Care Act) was enacted in March 2010. The Affordable Care Act mandated changes to the Medicaid and CHIP eligibility processes and policies to simplify enrollment and increase the share of eligible persons that are enrolled and covered. Some of the key changes applicable to all states, regardless of a state decision to expand Medicaid coverage, include:

- Use of Modified Adjusted Gross Income (MAGI) methodologies for income determinations and household compositions for most applicants.
- Use of the single streamlined application (or approved alternative) for intake of applicant information.

- Availability of multiple application channels for consumers to submit application information, such as mail, fax, phone, or on-line.
- Use of a HHS-managed data services hub for access to federal verification sources.
- Need for account transfers and data sharing between the state- or federal-Marketplace, Medicaid, and CHIP to avoid additional work or confusion by consumers.
- Reliance on data-driven processes for 12 month renewals.
- Use of applicant self-attestation of most eligibility elements as of January 1, 2014, with reliance on electronic third-party data sources for verification, if available.
- Enhanced 90 percent federal financial participation (FFP) match for the design, development, installation, or enhancement of the state's eligibility system.

In light of the implementation of the Affordable Care Act's major changes to the Medicaid and CHIP eligibility and enrollment provisions, and our continued efforts to comply with IPERIA and the CHIPRA, an interim change in methodology was implemented for conducting Medicaid and CHIP eligibility reviews under PERM. As described in the August 15, 2013 State Health Official (SHO) letter (SHO# 13-005), instead of the PERM and MEQC eligibility review requirements, we required states to participate in the Medicaid and CHIP Eligibility Review Pilots from FY 2014 to FY 2016 to support the development of a revised PERM methodology that provides informative, actionable information to states and allows CMS to monitor program administration. A subsequent SHO letter dated October 7, 2015 (SHO# 15-004) extended the Medicaid and CHIP Eligibility Review Pilots for one additional year.

B. Regulatory History

1. Medicaid Eligibility Quality Control (MEQC) Program

The MEQC program implements section 1903(u) of the Act, which defines erroneous excess payments as payments for ineligible persons and overpayments for eligible persons. Section 1903(u) of the Act instructs the Secretary not to make payment to a state with respect to the portion of its erroneous payments that exceed a 3 percent error rate, though the statute also permits the Secretary to waive all or part of that payment restriction if a state demonstrates that it cannot reach the 3 percent allowable error rate despite a good faith effort.

Regulations implementing the MEQC program are at 42 CFR subpart P – Quality Control. The regulations specify the sample and review procedures for the MEQC program and standards for good faith efforts to keep improper payments below the error rate threshold. From its implementation in 1978 until 1994, states were required to follow the as-promulgated MEQC regulations in what was known as the traditional MEQC program. Every month, states reviewed a random sample of Medicaid cases and verified the categorical and financial eligibility of the case members. Sample sizes had to meet minimum standards, but otherwise were at state option.

For cases in the sample found ineligible, the claims for services received in the review month were collected, and error rates were calculated by comparing the amount of such claims to the total claims for the universe of sampled claims. The state's calculated error rate was adjusted based on a federal validation subsample to arrive at a final state error rate. This final state error rate was calculated as a point estimate, without adjustment for the confidence interval resulting from the sampling methodology. States with error rates over 3 percent are subject under those regulations to a disallowance of FFP in all or part of the amount of FFP over the 3 percent error rate.

States prevailed in challenges to disallowances based on the MEQC system, at HHS's Departmental Appeals Board (DAB), HHS's final level of administrative review. The DAB concluded that the MEQC sampling protocol and the resulting error rate calculation were not

sufficiently accurate to provide reliable evidence to support a disallowance based on an actual error rate that exceeded the 3 percent threshold.

Although the MEQC system remained in place, we provided states with an alternative to the MEQC program that was focused on prospective improvements in eligibility determinations rather than disallowances. These changes, outlined in Medicaid State Operations (MSO) Letter #93-58 dated July 23, 1993, provided states with the option to continue operating a traditional MEQC program or to conduct what we termed “MEQC pilots” that did not lead to the calculation of error rates. These pilots continue today. States choosing the latter pilot option have generally operated, on a year-over-year basis, year-long pilots focused on state-specific areas of interest, such as high-cost or high-risk eligibility categories and problematic eligibility determination processes. These pilots review specific program areas to determine whether problems exist and produce findings the state agency can address through corrective actions, such as policy changes or additional training. Over time, most states have elected to participate in the pilots; 39 states now operate MEQC pilots, while just 12 maintain traditional MEQC programs.

2. Payment Error Rate Measurement (PERM) Program

Promulgated as a result of the IPIA and OMB guidance, a proposed rule published in the August 27, 2004 **Federal Register** (69 FR 52620) set forth proposed provisions establishing the PERM program by which states would annually be required to estimate and report improper payments in the Medicaid program and CHIP. The state-reported, state-specific improper payment rates were to be used to compute the national improper payment estimates for these programs.

In the October 5, 2005 **Federal Register** (70 FR 58260), we published a PERM interim final rule with comment period (IFC) that responded to public comments on the proposed rule

and informed the public of both our national contracting strategy and plan to measure improper payments in a subset of states. That IFC described that a state's Medicaid program and CHIP would be subject to PERM measurement just once every 3 years; the 3 year period is referred to as a cycle, and the year in which a state is measured is known as its PERM year. In response to the public comments from that IFC, we published a second IFC in the August 28, 2006 **Federal Register** (71 FR 51050) that reiterated our national contracting strategy to estimate improper payments in both Medicaid and CHIP fee-for-service (FFS) and managed care. We set forth, and invited comments on, state requirements for estimating improper payments due to Medicaid and CHIP eligibility determination errors. We also announced that a state's Medicaid program and CHIP would be reviewed during the same cycle.

In the August 31, 2007 **Federal Register** (72 FR 50490), we published a PERM final rule that finalized state requirements for: (1) Submitting claims to the federal contractors that conduct FFS and managed care reviews; (2) conducting eligibility reviews; and (3) estimating payment error rates due to errors in eligibility determinations.

3. 2010 Final Rule: Revisions to MEQC and PERM to Meet the CHIPRA Requirements

In the July 15, 2009 **Federal Register** (74 FR 34468), we published a proposed rule proposing revisions, as required by the CHIPRA, to the MEQC and PERM programs, including changes to the PERM review process. In the August 11, 2010 **Federal Register** (75 FR 48816), we published a final rule, which became effective on September 10, 2010, for the MEQC and PERM programs that codified several procedural aspects of the process for estimating improper payments in Medicaid and CHIP, including: changes to state-specific sample sizes to reduce state burden, the stratification of universes to obtain required precision levels, eligibility sampling requirements, the modification of review requirements for self-declaration or self-certification of eligibility, the exclusion of children enrolled through the ELE from the PERM

measurement, clearly defined “types of payment errors” to clarify that errors must affect payments for the purpose of the PERM program, a clearly defined difference resolution and appeals process, and state requirements for implementation of CAPs.

Section 601(e) of the CHIPRA required harmonizing the MEQC and PERM programs’ eligibility review requirements to improve coordination of the two programs, decrease duplicate efforts, and minimize state burden. To comply with the CHIPRA, the final rule granted states the flexibility, in their PERM year, to apply PERM data to satisfy the annual MEQC requirements, or to apply “traditional” MEQC data to satisfy the PERM eligibility component requirements.

The final rule permitted a state to use the same data, such as the same sample, eligibility review findings, and payment review findings, for each program. However, the CHIPRA permits substituting PERM and MEQC data only where the MEQC review is conducted under section 1903(u) of the Act, so only states using the “traditional” MEQC methodology may employ this substitution option. Also, each state, with respect to each program (MEQC and PERM) is still required to develop separate error/improper payment rate calculations.

II. Provisions of the Proposed Regulation

We are proposing the following changes to part 431 to address the eligibility provisions of the Affordable Care Act, as well as to make improvements to the PERM eligibility reviews.

A. MEQC Program Revision

Section 1903(u) of the Act requires the review of Medicaid eligibility to identify erroneous payments, but it does not specify the manner by which such reviews must occur. The MEQC program was originally created to implement the requirements of section 1903(u) of the Act, but the PERM program, implemented subsequent to MEQC and under other legal authority, likewise reviews Medicaid eligibility to identify erroneous payments. As noted previously, the

CHIPRA required harmonizing the MEQC and PERM programs and allowed for certain data substitution options between the two programs, to coordinate consistent state implementation to meet both sets of requirements and reduce redundancies. Because states are subject to PERM reviews only once every 3 years, we propose to meet the requirements in section 1903(u) of the Act through a combination of the PERM program and a revised MEQC program that resembles the current MEQC pilots, by which the revised MEQC program would provide measures of a state's erroneous eligibility determinations in the 2 off-years between its PERM cycle.

As previously noted, states currently may satisfy our requirements by conducting either a traditional MEQC program or MEQC pilots, with the majority of states (39) electing the latter due to the pilots' flexibility to target specific problematic or high-interest areas. The revised MEQC program we propose here would eliminate the traditional MEQC program and, instead, formalize, and make mandatory, the pilot approach. During the 2 off-years between each state's PERM years, when a state is not reviewed under the PERM program, we propose that it conduct one MEQC pilot spanning that 2 year period. The revised regulations we propose here would conform the MEQC program to how the majority of states have applied the MEQC pilots through the administrative flexibility we granted states decades ago to meet the requirements of section 1903(u) of the Act. Assuming this rule is finalized as proposed, we believe such MEQC pilots will provide states with the necessary flexibility to target specific problem or high-interest areas as necessary. As a matter of semantics, note that in this proposed rule we continue to use the term "pilots," which sometimes connote short-term studies or projects, because they are not fixed or defined projects, but, rather, as just described, states will have flexibility to adapt pilots to target particular areas.

We further propose to take a similar approach here to "freezing" error rates as we took when we initially introduced MEQC pilots 2 decades ago. In 1994, when we introduced MEQC

pilots we offered states the ability to “freeze” their error rates until they resumed traditional MEQC activities. In a similar vein, we now propose to freeze a state’s most recent PERM eligibility improper payment rate during the 2 off-years between a state’s PERM cycles, when the state will be conducting an MEQC pilot. As noted previously, section 1903(u) of the Act sets a 3 percent threshold for improper payments in any period or fiscal year and generally requires the Secretary to withhold payments to states with respect to the amount of improper payments that exceed the threshold. Therefore, we propose freezing the PERM eligibility improper payment rate as it allows each state a chance to test the efficacy of its corrective actions as related to the eligibility errors identified during its PERM year. Our proposal also allows states a chance to implement prospective improvements in eligibility determinations before having their next PERM eligibility improper payment measurement performed, where identified improper payments would be subject to potential payment reductions and disallowances under 1903(u) of the Act.

We propose to revise §431.800 to revise and clarify the MEQC program basis and scope.

We propose to delete §431.802 as federal financial participation, state plan requirements, and the requirement for the MEQC program to meet section 1903(u) of the Act would no longer be applicable to the revised MEQC program.

We propose to revise §431.804 by adding definitions for “corrective action,” “deficiency,” “eligibility,” “Medicaid Eligibility Quality Control (MEQC),” “MEQC Pilot,” “MEQC review period,” “negative case,” “off years,” “Payment Error Rate Measurement (PERM),” and “PERM year.”

We propose to revise the definitions for “active case,” and “eligibility error,” and remove “administrative period,” “claims processing error,” “negative case action,” and “state agency.”

We are adding, revising, or removing definitions to provide additional clarification for the proposed MEQC program revisions.

We propose to revise §431.806 to reflect the state requirements for the MEQC pilot program. Section 431.806 clarifies that following the end of a state's PERM year, it would have up to November 1 to submit its MEQC pilot planning document for our review and approval.

We propose to revise §431.810 to clarify the basic elements and requirements of the MEQC program.

We propose to revise §431.812 to clarify the review procedures for the MEQC program. As described earlier, the CHIPRA required harmonizing the PERM and MEQC programs and authorized us to permit states to use PERM to fulfill the requirements of section 1903(u) of the Act; the existing regulation at §431.812(f), permitting states to substitute PERM-generated eligibility data to meet MEQC program requirements, was promulgated under the CHIPRA authority. Given that the Congress, in the CHIPRA, directed the Secretary to harmonize the PERM and MEQC programs and expressly permitted states to substitute PERM for MEQC data, we believe that the PERM program, with the proposed revisions discussed in subpart Q, meets the requirements of section 1903(u) of the Act.

Our proposed approach would continue to harmonize the PERM and MEQC programs. It would reduce the redundancies associated with meeting the requirements of two distinct programs. As noted earlier, the CHIPRA, with certain limitations, allows for substitution of MEQC data for PERM eligibility data. Through our proposed approach, in their PERM year, states would participate in the PERM program, while during the 2 off-years between a state's PERM cycles they would conduct a MEQC pilot, markedly reducing states' burden. Moreover, we are proposing to revise the methodology for PERM eligibility reviews, as discussed below in §§431.960 through 431.1010. The MEQC pilots would focus on areas not addressed through

PERM reviews, such as negative cases and understated/overstated liability, as well as permit states to conduct focused reviews on areas identified as error-prone through the PERM program, so the proposed new cyclical PERM/MEQC rotation would yield a complementary approach to ensuring accurate eligibility determinations.

By conducting eligibility reviews of a sample of individuals who have received services matched with Title XIX or XXI funds, the PERM program would, under our proposal, continue to focus on identifying individuals receiving medical assistance under the Medicaid or CHIP programs who are, in fact, ineligible. Such PERM eligibility reviews conform with section 1903(u) of the Act's requirement that states measure erroneous payments due to ineligibility. Likewise, these eligibility reviews would continue under the MEQC pilots during states' off-years and include a review of Medicaid spend-down as a condition of eligibility, conforming with other state measurement requirements of section 1903(u) of the Act. We would calculate a state's eligibility improper payment rate during its PERM year, which would remain frozen at that level during its 2 off-years when it conducts its MEQC pilot. Again, freezing states' eligibility improper payment rates between PERM cycles would allow states time to work on effective and efficacious corrective actions which would improve their eligibility determinations. This approach also encourages states to pursue prospective improvements to their eligibility determination systems, policies, and procedures before their next PERM cycle, in which an eligibility improper payment rate would be calculated with the potential for payment reductions and disallowances to be invoked, in the event that a state's eligibility improper payment rate is above the 3 percent threshold.

1. Revised MEQC Review Procedures

For more than 2 decades, the majority of states have used the flexibility of MEQC pilots to review state-specific areas of interest, such as high-cost or high-risk eligibility categories and

problematic eligibility determination processes. This flexibility has been beneficial to states because it made MEQC more useful from a corrective action standpoint.

We propose that MEQC pilots focus on cases that may not be fully addressed through the PERM review, including, but not limited to, negative cases and payment reviews of understated and overstated liability. Still, under our proposal, states would retain much of their current flexibility. In §431.812, we propose that states must use the MEQC pilots to perform both active and negative case reviews, but states would have flexibility surrounding their active case review pilot. In the event that a state's eligibility improper payment rate is above the 3 percent threshold for two consecutive PERM cycles, we propose this flexibility would decrease as states would be required to comply with CMS guidance to tailor the active case reviews to a more appropriate MEQC pilot which would be based upon a state's PERM eligibility findings. In order to ensure states with consecutive PERM eligibility improper payment rates over the threshold, are identifying and conducting MEQC active case reviews which are appropriate during their off-years, CMS would provide direction for conducting a MEQC pilot that would suitably address the error-prone areas identified through the state's PERM review. Both the PERM and MEQC pilot programs are operationally complementary, and should be treated in a manner that allows for states to review identified issues, develop corrective actions, and effectively implement prospective improvements to their eligibility determinations.

Active and negative cases represent the eligibility determinations made for individuals which either approve or deny an individual's eligibility to receive benefits and/or services under Medicaid or CHIP. Individuals who are found to be eligible and authorized to receive benefits/services are termed active cases, whereas individuals who are found to be ineligible for benefits are known as negative cases. As proposed at §431.812(b)(3) a state may focus its active case reviews on three defined areas, unless otherwise directed by us or, as proposed at

§431.812(b)(3)(i), it may perform a comprehensive review that does not limit its review of active cases. Additionally, we propose that the MEQC pilots must include negative cases because we also propose to eliminate PERM's negative case reviews; our proposal would ensure continuing oversight over negative cases to ensure the accuracy of state determinations to deny or terminate eligibility.

Under the new MEQC pilot program, we propose that states review, a minimum total of 400 Medicaid and CHIP active cases. We propose that at least 200 of those reviews must be Medicaid cases and expect that states will include some CHIP cases, but, beyond that, we propose that states would have the flexibility to determine the precise distribution of active cases. For example, a state could sample 300 Medicaid and 100 CHIP active cases; it would describe its active sample distribution in its MEQC pilot planning document that it would submit to us for approval. Under the new MEQC pilot program, we also propose that states review, at a minimum, 200 Medicaid and 200 CHIP negative cases. Currently, under the PERM program, states are required to conduct approximately 200 negative case reviews for each the Medicaid program and CHIP (204 is the base sample size, which may be adjusted up or down from cycle to cycle depending on a state's performance). We propose a minimum total negative sample size of 400 (200 for each program) for the proposed MEQC pilots because, as mentioned above and discussed further below, we propose to eliminate PERM's negative case reviews.

Historically, MEQC's case reviews (both active and negative) focused solely on Medicaid eligibility determinations. Here, we propose that the new MEQC pilots would now include both Medicaid and CHIP eligibility case reviews. Because we propose to eliminate PERM's negative case reviews, it is important that we concomitantly expand the MEQC pilots to include the review of no less than 200 CHIP negative cases to ensure that CHIP applicants are not inappropriately denied or terminated from a state's program. In the event that CHIP funding

should end, then states would be required to review only Medicaid active and negative cases, as there would no longer be any cases associated with CHIP funding.

We will provide states with guidelines for conducting these MEQC pilots, and we propose that states must submit MEQC pilot planning documents for CMS's approval. This approach will ensure that states are planning to conduct pilots that are suitable and in accordance with our guidance.

This proposed rule would require states to conduct one MEQC pilot during their 2 off-years between PERM cycles. We propose that the MEQC pilot review period span 12 months, beginning on January 1, following the end of the state's PERM review period. For instance, if a state's PERM review period is July 1, 2018 to June 30, 2019, the next proposed MEQC pilot review period would be January 1 - December 31, 2020. We propose at §431.806 that a state would have up to November 1 following the end of its PERM review period to submit its MEQC pilot planning document for CMS review and approval. Following a state's MEQC pilot review period, we propose it would have up to August 1 to submit a CAP based on its MEQC pilot findings.

Following publication of the final rule, states will not all be at the same point in the MEQC pilot program/PERM timeline. The impact of the proposed MEQC timeline for each cycle of states is clarified below to assist each cycle of states in understanding when the proposed MEQC requirements would apply.

- Cycle 1 States: First PERM review period under new rule: July 2017 – June 2018; First MEQC pilot planning document due by November 1, 2018; MEQC review period would be January 1 – December 31, 2019; MEQC pilot program findings and CAP reported to CMS by August 1, 2020.

- Cycle 2 States: Further CMS guidance will be provided regarding the implementation of a modified MEQC pilot program that will occur prior to the beginning of your first PERM cycle under the new rule. First PERM review period under new rule: July 2018 – June 2019; Second MEQC pilot planning document due by November 1, 2019.

- Cycle 3 States: First MEQC pilot planning document due by November 1, 2017; MEQC review period would be January 1 – December 31, 2018; MEQC pilot program findings and CAP reported to CMS by August 1, 2019; First PERM review period under new rule: July 2019 – June 2020.

2. MEQC Pilot Planning Document

We propose to revise §431.814 to clarify the revised sampling plan and procedures for the MEQC pilot program. We propose that states be required to submit, for our approval, a MEQC Pilot Planning Document that would detail how it would propose to perform its active and negative case reviews. This process is consistent with that used historically with MEQC pilots and also with the FY 2014 – 2017 Medicaid and CHIP Eligibility Review Pilots. Prior to the first proposed submission cycle, we would provide states with guidance containing further details informing them of what information would need to be included in the MEQC Pilot Planning Document.

3. Timeline and Reporting for MEQC pilot program

We propose to revise §431.816 to clarify the case review completion report submission deadlines. We propose that states be required to report, through a CMS-approved website and in a CMS-specified format, on all sampled cases by August 1 following the end of the MEQC review period, which we believe will streamline the reporting process and ensure that all findings are contained in a central location.

We propose to revise §431.818 to remove the mailing requirements and the time requirement.

4. MEQC Corrective Actions

We propose to revise §431.820 to clarify the corrective action requirements under the proposed MEQC pilot program. Corrective actions are critical to ensuring that states continually improve and refine their eligibility processes. Under the existing MEQC program, states must conduct corrective actions on all identified case errors, including technical deficiencies, and we propose here that states continue to be required to conduct corrective actions on all errors and deficiencies identified through the proposed MEQC pilot program.

We propose that states report their corrective actions to CMS by August 1 following completion of the MEQC pilot review period, and that such reports also include updates on the life cycles of previous corrective actions, from implementation through evaluation of effectiveness.

We propose to delete §431.822, as we would no longer be performing a federal case eligibility review of the revised MEQC program.

5. MEQC Disallowances

Section I.B.1, above, provides a detailed regulatory history of CMS's implementation of the MEQC program, and, in conformity with CMS's policy since 1993, we propose not using the revised MEQC pilot program to reduce payments or to institute disallowances. Instead, we propose to formalize the MEQC pilot process to align all states in one cohesive pilot approach to support and encourage states during their 2 off-years between PERM cycles to address, test, and implement corrective actions that would assist in the improvement of their eligibility determinations. This approach also better harmonizes and synchronizes the MEQC pilot and PERM programs, leaving them operationally complementary. Additionally, our proposal would

be advantageous to all states as they each would be exempt from potential payment reductions and disallowances while conducting their MEQC pilot, therefore placing the main focus of the pilots solely on the refinement and improvement of their eligibility determinations. Based on this approach, we propose that each state's eligibility improper payment rate would be calculated in its PERM year, and that its rate would be frozen at that level during its off-years when it would conduct an MEQC pilot and implement corrective actions.

As previously discussed, the CHIPRA authorized certain PERM and MEQC data substitution, and we believe that the PERM eligibility improper payment rate determination methodology satisfies the requirements of section 1903(u) of the Act to be used for that provision's payment reduction (and potential disallowance) requirement. Section 1903(u)(1)(B) of the Act permits the Secretary to waive, in whole or part, section 1903(u)(1)(a)'s required payment reductions if a state is unable to reach an allowable improper payment rate for a period or a fiscal year despite the state's good faith effort. What constitutes a state's good faith effort is outlined at the proposed §431.1010(b). As part of the proposed good faith effort, we propose that a state's participation in the proposed MEQC pilot program in conformity with §§431.800 through 431.820 of this proposed regulation, and its implementation of PERM CAPs in accordance with §431.992 would be essential elements to the showing of a state's good faith effort. Conversely, should a state's eligibility improper payment rate exceed 3 percent, and should that state fail to comply with all elements of §431.1010(b) in demonstrating a good faith effort, we propose, in accordance with section 1903(u)(1)(a) of the Act, to reduce its FFP for medical assistance by the percentage by which the lower limit of its eligibility improper payment rate exceeds three percent. We define a state's failure to comply with all elements of the proposed §431.1010(b), as a lack of a good faith effort to reach the allowable error rate. We propose to use the lower limit of the eligibility improper payment rate per guidance issued by us

prior to the implementation of the present MEQC pilots. Therefore, we propose to require states to use PERM to meet section 1903(u) of the Act requirements in their PERM years, and that potential payment reductions or disallowances only be invoked under the PERM program.

Therefore, we propose to delete §431.865.

6. Payment Error Rate Measurement (PERM) Program

We are proposing the revisions described below to the PERM program. Our proposed PERM eligibility component revisions have been tested and validated through multiple rounds of PERM model pilots with 15 states and through discussion with state and non-state stakeholders. The PERM model pilots were distinct from the separate FY 2014-2017 Medicaid and CHIP Eligibility Review Pilots, and were used to assess, test, and recommend changes to PERM's eligibility component review process based on the changes implemented by the Affordable Care Act. Specifically, we tested, and asked for stakeholder feedback on, options in the following areas (below, there is more detail on each):

- Universe definition
- Sample unit definition
- Eligibility Case review approach
- Feasibility of using a federal contractor to conduct the eligibility case reviews
- Difference resolution and appeals process

Through the PERM model pilots, we have determined that each of the proposed changes support the goals of the PERM program and will produce a valid, reliable eligibility improper payment rate. We also interviewed participating states, as well as a select group of other states, to receive feedback on the majority of the proposed changes, and, to the extent possible, we have addressed state concerns in this proposed rule.

7. Payment Error Rate Measurement (PERM) Measurement Review Period

Since PERM began in 2006, the measurement has been structured around the federal fiscal year, (FFY) with states submitting FFS claims and managed care payments with paid dates that fall in the FFY under review. But, a data collection centered around the FFY has made it perennially challenging to finalize the improper payment rate measurement and conduct all the related reporting to support an improper payment rate calculation by November of each year. Therefore, to provide states and CMS additional time to complete the work related to each PERM cycle prior to the annual improper payment rate publication in the AFR, to better align PERM with many state fiscal year timeframes, and to mirror the review period currently utilized in the Medicare FFS improper payment measurement program, we propose to change the PERM review period from a FFY to a July through June period. We propose to begin this change with the Cycle 1 states, whose PERM cycle would have started on October 1, 2017, so that Cycle 1 states would submit their 1st and 4th quarters of FFS claims and managed care payments with paid dates between, respectively, July 1 - September 30, 2017 and April 1 - June 30, 2018. Subsequent cycles would follow a similar review period.

We propose to revise §431.950 to clarify the requirement for states and providers to submit information and provide support to federal contractors to produce national improper payment estimates for Medicaid and CHIP. .

We propose various revisions to §431.958 to add, revise, or remove definitions to provide greater clarity for the proposed PERM program changes. Proposed additions and revisions include definitions for “appeals,” “corrective action,” “deficiency,” “difference resolution,” “disallowance,” “Eligibility Review Contractor (ERC),” “error,” “federal contractor,” “Federally facilitated marketplace-determination (FFM-D),” “Federal financial participation,” “finding,” “Improper payment rate,” “Lower limit,” “PERM review period,” “recoveries,” “Review Contractor (RC),” “Review year,” “State-specific sample size,” “State eligibility system,” “State

error,” “State payment system,” “Statistical Contractor (SC),” and removing the definitions of “active case,” “active fraud investigation,” “agency,” “case,” “case error rate,” “case record,” “last action,” “negative case,” “payment error rate,” “payment review,” “review cycle,” “sample month,” “state agency,” and “undetermined.”

We propose to revise §431.960 to remove references to negative case reviews and improper payments because a separate negative case review will no longer be a part of the PERM review process, as well as to provide greater clarity for the proposed PERM program changes. Note that while a separate negative case review would not be conducted as part of the proposed PERM review process, it could be possible for a negative case to be reviewed, because the claims universe includes claims that have been denied. If a sampled denied claim was denied because the beneficiary was not eligible for Medicaid/CHIP benefits on the date of service, PERM would review the state’s decision to deny eligibility.

We propose to revise §431.972(a) to specify that states would be required to submit FFS claims and managed care payments for the new PERM Review Period.

8. Eligibility Federal Review Contractor and State Responsibilities

Under the existing §431.974, states conduct PERM eligibility reviews. Since the first PERM eligibility cycle in FY 2007, we have found that conducting PERM eligibility reviews significantly burdens state resources, and because the reviews require substantial staff resources, many states have struggled to meet review timelines. Moreover, we have found that having states conduct PERM eligibility reviews has created significant opportunity for the PERM eligibility review guidance to be misinterpreted and inconsistently applied across states, with, for example, states having difficulty interpreting the universe definitions and case review guidelines.

To confront these challenges, we propose to utilize a federal contractor (known as the ERC) to conduct the eligibility reviews on behalf of states. This proposal would concomitantly

reduce states' PERM program burden and ensure more consistent guidance interpretation, thereby reducing case review inconsistencies across states and improving eligibility processes related to case reviews and reporting. A federal contractor would be able to apply consistent standards and quality control processes for the reviews and improve CMS's ability to oversee the process, so improper payments would be reported consistently across states. Moreover, the ERC would allow us to gain a better national view of improper payments to better support the corrective action process and ensure accurate and timely eligibility determinations, while a third-party review team would be more consistent with standard auditing practices and our other improper payment measurement programs.

Our PERM model pilot testing has confirmed that having a federal contractor conduct eligibility reviews is feasible and improves our oversight of the process, as an experienced federal contractor can apply PERM guidance consistently across states while continuing to recognize unique state eligibility policies, processes, and systems. Further, through the pilots, we have developed processes to ensure that the federal contractor works collaboratively with state staff to ensure that the reviews are consistent with state eligibility policies and procedures.

While states would not, under our proposal, continue to conduct PERM eligibility reviews, we envision that they would still play a role, as needed, in supporting the federal contractor. We therefore propose to add state supporting role requirements by proposing to revise §431.970 to outline data submission and state systems access requirements to support the PERM eligibility reviews and the ERC.

Under §431.10(c)(1)(i)(A)(3), state Medicaid agencies may delegate authority to determine eligibility for all or a defined subset of individuals to the Exchange, including Exchanges operated by a state or by HHS. Those states that have delegated the authority to make Medicaid/CHIP eligibility determinations to an Exchange operated by HHS, known as the

Federally Facilitated Marketplace (FFM), are described as determination states, or FFM-D states. By contrast, those states that receive information from the FFM, which makes assessments of Medicaid/CHIP eligibility, but where the applicant's account is transferred to the state for the final eligibility determination, are known as assessment states, or FFM-A states.

We propose that states would be responsible for providing the ERC with eligibility determination policies and procedures, and any case documentation requested by the ERC, which could include the account transfer (AT) file for any claims where the individual was determined eligible by the FFM in a determination state (FFM-D), or was passed on to the state by the FFM for final determination in assessment states (FFM-A).

Further, under this proposal, if the ERC finds that it cannot complete a review due to insufficient supporting documentation, it would expect the state to provide it. States would determine how to obtain the requested documentation (we do not propose to charge the ERC with conducting additional outreach, such as client contact) and, if unable to do so to enable to ERC to complete the review, the ERC would cite the case as an improper payment due to insufficient documentation. We also propose that states would be responsible for providing the ERC with direct access to their eligibility system(s). A state's eligibility system(s) (including any electronic document management system(s)) contains data the ERC must review, including application information, third party data verification results, and copies of required documentation (for example, pay stubs), and we believe that allowing the ERC direct access would best enable it to timely and accurately complete its reviews and reduce state burden that would otherwise be required to inform the ERC's reviews.

To ensure that states continue to have a measure of oversight, however, we propose allowing states the opportunity to review the ERC's case findings prior to their being finalized and used to calculate the national and state improper payment rate. Through a difference

resolution and appeals process, states would have the opportunity to resolve disagreements with the ERC. Based on our pilot testing, we believe that open communication between the state and the ERC would best foster states' understanding of the review process and the basis for any findings.

9. Eligibility Review Procedures

As just discussed, we are proposing that a federal contractor would conduct the eligibility case reviews, and states' responsibilities would therefore be limited. Because we propose state responsibilities at §431.970, we propose to delete §431.974.

10. Eligibility Sampling Plan

We propose to delete §431.978; because the proposed ERC would conduct the eligibility reviews, states would no longer be required to submit a sampling plan. In place of the sampling plan, the ERC would draft state-specific eligibility case review planning documents outlining how it would conduct the eligibility review, including the relevant state-specific eligibility policy and system information.

11. Eligibility Review Procedures

We propose to delete §431.980; this section presently specifies the review procedures required for states to follow while performing the PERM eligibility component reviews. States would no longer be required to conduct the PERM eligibility component reviews, because the proposed ERC would conduct the eligibility reviews.

12. Eligibility Case Review Completion Deadlines and Submittal of Reports

We propose to delete §431.988; this section presently specifies states' requirements and deadlines for reporting PERM eligibility review data, which functions we propose to transition to an ERC.

13. Payment System Access Requirements

The Claims Review Contractor (RC) currently conducts PERM reviews on FFS and managed care claims for the Medicaid program and CHIP, and is required to conduct Data Processing (DP) reviews on each sampled claim to validate that the claim was processed correctly based on information found in the state's claim processing system and other supporting documentation maintained by the state. We believe that in order for the RC to review claims during the review cycle, reviewers would need remote or on-site access to appropriate state systems. If the RC is unable to review pertinent claims information, and the state is not able to comply with all information submission and systems access requirements as specified in the proposed rule, the payment under review may be cited as an error due to insufficient documentation.

To facilitate the RC's reviews, we propose that states grant it access to systems that authorize payments, including: FFS claims payments; Health Insurance Premium Payment (HIPP) payments; Medicare buy-in payments; aggregate payments for providers; capitation payments to health plans; and per member per month payments for Primary Care Case Management (PCCM) or non-emergency transportation programs. We propose that states also grant the RC access to systems that contain beneficiary demographics and provider enrollment information to the extent such information is not included in the payment system(s), and to any imaging systems that contain images of paper claims and explanation of benefits (EOBs) from third party payers or Medicare.

Experience has demonstrated that some states have allowed the RC only partial and/or untimely systems access, which we believe has led to a slower review process. Based on our discussions with the states, we believe their sometimes permitting just limited systems access is due to a lack of processes to grant access (for example, requiring contractors to complete access forms and training) rather than state bans on providing outside contractors with access due to

privacy or cost concerns. Therefore, we propose adding paragraphs (c) and (d) to §431.970, which would require states to provide access to appropriate and necessary systems.

14. Universe Definition

To meet IPERIA requirements, the samples used for PERM eligibility reviews must be taken from separate universes: one that includes Title XIX Medicaid dollars and one that includes Title XXI CHIP dollars. Section 431.978(d)(1) currently defines the Medicaid and CHIP active universes as all active Medicaid or CHIP cases funded through Title XIX or Title XXI for the sample month, with certain exclusions. Developing an accurate and complete universe is essential to developing a valid, accurate improper payment rate.

In previous PERM cycles, sampling universe development has been one of the most difficult steps of the eligibility review. Varying data availability and system constraints have made it challenging to maintain consistency in state-developed eligibility universes; developing the eligibility universe may require substantial staff resources, and the process may take several data pulls that are often conducted by IT staff or outside contractors not closely involved in the PERM eligibility review process.

During the PERM model pilots, we tested three PERM eligibility review universe definition options, including defining the universe by: (1) Eligibility determinations and redeterminations (that is, a universe of eligibility decisions); (2) actual beneficiaries or recipients (that is, a universe of eligible individuals); and (3) claims/payments (that is, a universe of payments made). We found that the third approach, defining the universe by the claims/payments, was best; PERM was designed to meet the IPERIA requirements of calculating a national Medicaid and CHIP improper payment rate, so having the eligibility reviews tied directly to a paid claim ensures that PERM only reviews those beneficiaries or recipients who have had services paid for by the state Medicaid or CHIP agency. Accordingly, for the PERM

eligibility review active universe we propose using the definition at §431.972(a), and deleting the current PERM eligibility review universe requirements in §431.974 and §431.978. The PERM claims component requires state submission of Medicaid and CHIP FFS claims and managed care payments on a quarterly basis; state submission responsibilities are defined under §431.970. These claims and payments are rigorously reviewed by the federal statistical contractor, and the process has extensive, thorough quality control procedures that have been used for several PERM cycles and have been well-tested.

We believe that this universe definition leverages the claims component of PERM and supports efficient use of resources, as the universe would already be developed on a consistent basis for the PERM claims component. By this proposed change, eligibility reviews using a claims universe would be tied to payments and be more consistent with IPERIA, state burden would be minimized by harmonizing PERM claims and eligibility universe development, and federal and state resources would no longer be spent on eligibility reviews that potentially could not be tied to payments (for example, eligibility reviews conducted on beneficiaries that did not receive any services).

Through our pilot testing, we have also determined that the claims universe does not result in a substantially different rate of case error. However, sampling from this universe did result in a higher proportion of non-MAGI cases because enrollees in such eligibility categories are likely to have higher health care service utilization, and, therefore, have more associated FFS claims. Because PERM is designed to focus on improper payments, we believe it is appropriate to use a sample that focuses on individuals who are linked to the bulk of Medicaid and CHIP payments. However, because eligibility will be reviewed for both FFS claims and managed care capitation payments, MAGI cases will be subject to a PERM eligibility review, primarily through the review of eligibility for individuals who have managed care capitations payments on

their behalf, as many states have chosen to enroll individuals in MAGI eligibility categories in managed care. Further, states can choose to focus on further Medicaid and CHIP reviews of MAGI cases in the proposed MEQC pilot reviews they would conduct during their off-year pilots.

While it is possible for a claim to be associated with a negative case, as mentioned previously, the claims universe does not support a negative PERM eligibility case rate. Because IPERIA focuses on payments, the statute does not require determining a negative case rate. The proposed MEQC pilot reviews that states would conduct on off-years would be used to review Medicaid and CHIP negative cases.

15. Inclusion of FFM-D Cases in the PERM Review

As previously noted, §431.10(c)(1)(i)(A)(3) permits state Medicaid agencies to delegate authority to determine eligibility for all or a defined subset of individuals to the Exchange, including Exchanges operated by a state or by HHS. We propose that, in FFM-D states, cases determined by the FFM (referred to as FFM-D cases) could be reviewed if a FFS claim or managed care payment for an individual determined eligible by the FFM is sampled. Although FFM-D states are required to maintain oversight of their Medicaid/CHIP programs per §435.1200(c)(3), they also enter into an agreement per §435.1205 (b)(2)(i)(A) by which they must accept the determinations of Medicaid/CHIP eligibility based on MAGI made by another insurance affordability program (in this case, the FFM).

Federal regulations permit states to delegate authority for MAGI-based Medicaid and CHIP eligibility determinations to the FFM and require them to accept those determinations. States have an overall responsibility for oversight of all Medicaid and CHIP eligibility determinations, but, with respect to the FFM delegation, they are required to accept FFM determinations without further review or discussion on a case-level basis, making it difficult for

states to address improper payments on a case-level basis. Therefore, we propose that case-level errors resulting solely from an FFM determination of MAGI-based eligibility that the state was required to accept be included only in the national improper payment rate, not the state rate. Conversely, we propose that errors resulting from incorrect state action taken on cases determined and transferred from the FFM, or from the state's annual redetermination of cases that were initially determined by the FFM, be included in both state and national improper payment rates. Examples of errors that we propose would be included in both state and national improper payment rates include, but are not limited to: (1) where a case is initially determined and transferred from the FFM, but the state then fails to enroll an individual in the appropriate eligibility category; and (2) errors resulting from initial determinations made by a state-based Exchange.

We propose revisions to §431.960(e) and §431.960(f) to clarify that we would distinguish between cases that are included in a state's, and the national, improper payment rate. Although we are proposing this distinction for improper payment measurement program purposes, this distinction does not preclude the single state agency from exercising appropriate oversight over eligibility determinations to ensure compliance with all federal and state laws, regulations and policies. We also propose revisions to §431.992(b) to make clear that states would be required to submit PERM corrective actions only for errors included in state improper payment rates.

16. Sample Size

Establishing adequate sample sizes is critical to ensuring that the PERM improper payment rate measurement meets IPERIA statistical requirements. In accordance with IPERIA, PERM is focused on establishing a national improper payment rate and the national improper payment rate must meet the precision level established in OMB Circular A-123, which is a 2.5 percent precision level at a 90 percent confidence interval. As an additional goal, although not

required by IPERIA, we have always strived to achieve state level improper payment rates within a 3 percent precision level at a 95 percent confidence interval. However, as discussed in the Regulatory Impact Analysis, we recognize achieving this level of precision in all states poses some challenges and is not always possible.

Previously, state-specific sample sizes were calculated prior to each cycle and the national annual sample size was the aggregate of the state-specific sample sizes. State-specific sample sizes were based on past state PERM improper payment rates. We propose establishing a national annual sample size that would meet IPERIA's precision requirements at the national level, and then distributing the sample across states to maximize precision at the state level, where possible. We also propose that the state-specific sample sizes would be chosen to maximize precision based on state characteristics, including a history of high expenditures and/or past state PERM improper payment rates. We recognize that the precision of past estimates of state-specific improper payment rates has varied. We request public comment on this proposed approach, its benefits, limitations, and any potential alternatives. We believe that, relative to our prior approach, the proposed approach would more effectively measure and reduce national improper payments and would also provide more stable state-specific sample sizes, as the sample size would be less responsive to changes in improper payment rates from cycle to cycle. A more stable state-specific sample size may assist with state level planning. Further, it will allow us to exercise more control over the PERM program's budget by establishing a national sample size. On the other hand, like its predecessor, the proposed approach may not yield improper payment estimates at the state level within a 3 percent precision level at a 95 percent confidence interval for all states (due to underpowered sample size). We will develop specific sampling plans for PERM cycles that occur after publication of the final rule. We will continue to calculate a national improper payment rate within a 2.5 percent precision level at a 90 percent confidence

interval as required by IPERIA. Likewise, we will continue to strive to achieve state improper payment rates within a 3 percent precision level at a 95 percent confidence interval precision. In the future, as information improves or new priorities are identified, we may identify additional factors that should be taken into account in developing state-specific sample sizes.

In practice, we anticipate having the ability to vary the number of data processing, medical, and eligibility reviews performed on each of the sampled claims. Under this approach, each sampled claim may not undergo all three types of reviews, which would allow us to more efficiently allocate the types of reviews performed. Conducting more reviews on payments that are likely to have problems gives us better information to implement effective corrective actions, which could assist in reducing improper payments. For example, after eligibility reviews resume, we may determine that there are few eligibility improper payments for clients associated with managed care claims; there thus might be a limited benefit to conducting eligibility reviews on all sampled managed care claims, and we might reduce the number of those reviews. This approach would allow us to optimize PERM program expenditures so we do not waste resources conducting reviews unlikely to provide valuable insight on the causes of improper payments.

We note above that conducting reviews on areas more likely to have problems results in more information to inform corrective actions versus conducting more reviews on areas that are likely to be correct. It is important to note that state corrective actions are not impacted by varying levels of state-specific improper payment rate precision. As we describe later in this proposed rule, states are required to submit corrective action plans that address all improper payments and deficiencies identified.

17. Data Processing, Medical, and Eligibility Improper Payment Definitions

We propose clarifying in §431.960(b)(1), §431.960(c)(1), and §431.960(d)(1) that improper payments are defined as both federal and state improper payments. We believe this

change would allow us to cite federal improper payments in circumstances where states make an incorrect eligibility category assignment that would result in the incorrect federal medical assistance percentage (FMAP) being claimed by the state. Previously, improper payments were only cited if the total computable amount – the federal share plus the state share – was incorrect. Under the Affordable Care Act, beneficiaries in the newly eligible adult group receive a higher FMAP rate than other eligibility categories. As a result, incorrect enrollment of an individual in the newly eligible adult category may result in improper federal payments even though the total computable amount may be correct. Although there were eligibility categories that could receive higher FMAP rates previously, the size of the newly eligible adult category makes it critical for us to have the ability to cite federal improper payments to achieve an accurate PERM improper payment rate.

18. Difference Resolution and Appeals Process

Because we propose to use an ERC to conduct the eligibility case reviews, we likewise propose that the ERC conduct the eligibility difference resolution and appeals process, which would mirror how that process is conducted with respect to FFS claims and managed care payments. The difference resolution and appeals process used for the FFS and managed care components of the PERM program is well developed and has allowed us to adequately resolve disagreements between the RC and states. We have revised §431.998 to include the proposed eligibility changes for the difference resolution and appeals process.

Additionally, in the text currently at §431.998(d), we propose deleting the statement about CMS recalculating state-specific improper payment rates, upon state request, in the event of any reversed disposition of unresolved claims. We propose that the recalculation be performed whenever there is a reversed disposition; no state request is needed.

19. Corrective Action Plans

Under §431.992, states are required to submit CAPs to address all improper payments and deficiencies found through the PERM review. We propose that states would continue to submit CAPs that address eligibility improper payments, along with improper payments found through the FFS and managed care components. We propose to revise §431.992(a) to clarify that states would be required to address all errors included in the state improper payment rate at §431.960(f)(1).

We propose to revise §431.992 to provide additional clarification for the PERM CAP process. We propose minor revisions to the regulatory text to reflect the current corrective action process and provide additional state requirements, consistent with the CHIPRA. Proposed revisions include replacing “major tasks” at §431.992(b)(3)(ii)(A) with “corrective action,” to improve clarity. Other proposed clarifications would also be provided at §431.992(b)(3)(ii)(A) through §431.992(b)(3)(ii)(E).

We also propose adding language to clarify the state responsibility to evaluate corrective actions from the previous PERM cycle at §431.992(b)(4), and a requirement for states, annually and when requested by CMS, to update us on the status of corrective actions. We propose requesting updates on state corrective action implementation progress on an annual basis, a frequency that would enable us fully monitor corrective actions and ensure that states are continually evaluating the effectiveness of their corrective actions.

Additionally, we propose to add language in §431.992 to specify further CAP requirements should a state’s PERM eligibility improper payment rate exceed the allowable threshold of 3 percent per section 1903(u) of the Act for consecutive PERM years. This proposal only pertains to a state’s additional CAP requirements related to the PERM eligibility improper payment rate, and does not extend to the FFS and managed care components. As the allowable threshold for eligibility is set by section 1903(u) of the Act, this will not change from year to

year. The improper payment rate targets for FFS and managed care are not constant, therefore, it is not judicious to hold states accountable to meet a target that is variable.

We propose to require states whose eligibility improper payment rates exceed the 3 percent threshold for consecutive PERM years to provide status updates on all corrective actions on a more frequent basis, as well as include more details surrounding the state's implementation and evaluation of all corrective actions, than would be required for those states which did not have eligibility improper payment rates over the 3 percent threshold for consecutive PERM years. As noted above, we anticipate typically requesting updates on corrective actions on an annual basis, however, for those states with consecutive PERM eligibility improper payment rates above the allowable threshold, we propose to require updates every other month. Such states would also be required to submit information about any setbacks and provide alternate corrective actions or manual workarounds, in the event that their original corrective actions are unattainable or no longer feasible. This would ensure states have additional plans in place, if the original corrective action cannot be implemented as planned. Also, states would be required to submit actual examples demonstrating that the corrective actions have led to improvements in operations, and explanations for how these improvements are efficacious and will assist the state to reduce both the number of errors cited and the state's next PERM eligibility improper payment rate. Moreover, we propose that states be required to submit an overall summary that clearly demonstrates how the corrective actions planned and implemented would provide the state with the ability to meet the 3 percent threshold upon their next PERM eligibility improper payment rate measurement.

20. PERM Disallowances

As previously stated regarding MEQC Disallowances, we are proposing to require states to use PERM to meet section 1903(u) of the Act requirements in their PERM years, and to no

longer require the proposed MEQC pilot program to satisfy the requirements of section 1903(u) of the Act. We propose to require states to use PERM to meet section 1903(u) of the Act requirements, as this approach has been supported by the CHIPRA through its data substitution authorization between the PERM and MEQC programs. Moreover, requiring the PERM program to satisfy IPERIA requirements and requiring a separate program to satisfy the erroneous excess payment measurement and payment reduction/disallowance requirements of section 1903(u) of the Act, when PERM is capable of meeting the requirements of both, would be contrary to the CHIPRA's requirement to harmonize PERM and MEQC. Therefore, based on the ability of the PERM program to meet both the requirements of section 1903(u) of the Act and IPERIA, we propose that in a state's PERM year, a state's PERM eligibility improper payment rate be used to satisfy both IPERIA's improper payment requirements and 1903(u) the Act's erroneous excess payments and payment reduction/disallowance requirements.

If a state's PERM eligibility improper payment rate is above the 3 percent allowable threshold per section 1903(u) of the Act, it would be subjected to potential payment reductions and disallowances. However, if the state has taken the action it believed was needed to meet the threshold, failed to achieve that level, the state may be eligible for a good faith waiver as outlined in §431.1010. Essential elements of a state's showing of a good faith effort include the state's participation in the MEQC pilot program in accordance with subpart P (§431.800 through §431.820) and implementation of PERM CAPs in accordance with §431.992.

Absent CMS's approval, a state's failure to comply with both the MEQC pilot program requirements and PERM CAP requirements, would be considered a state's failure to demonstrate a good faith effort to reduce its eligibility improper payment rate. Again, absent our approval, we would not grant a good faith waiver for any state that either does not comply with the MEQC pilot program requirements or does not implement a PERM corrective action plan. We also

propose that the requirements under section 1903(u) of the Act would not become effective until a state's second PERM eligibility improper payment rate measurement has occurred, as an earlier effective date would not give states a chance to demonstrate, if needed, a good faith effort.

Under this proposed regulation, we would reduce a state's FFP for medical assistance by the percentage by which the lower limit of the state's eligibility improper payment rate exceeds the 3 percent threshold should a state fail to demonstrate a good faith effort. We propose to use the lower limit of the improper payment rate per previous MEQC guidance issued by us prior to the implementation of MEQC pilots in 1993. We believe that utilizing the lower limit of the error rate for disallowance purposes will assist in ensuring there is reliable evidence that a state's error rate exceeds the 3 percent threshold. This approach addresses the varying levels of state-specific improper payment rate precision as discussed in the sample size section above.

Therefore, we propose to add §431.1010, which establishes rules and procedures for payment reductions and disallowances of federal financial participation (FFP) in erroneous medical assistance payments due to eligibility improper payments, as detected through the PERM program. Federal medical assistance funds include all service-based fee-for-service, managed care, and aggregate payments which are included in the PERM universe. Exclusions from the federal medical assistance funds for disallowance purposes include non-service related costs (for example, administrative, staffing, contractors, systems) as well as certain payments for services not provided to individual beneficiaries such as Disproportionate Share Hospital (DSH) payments to facilities, grants to State agencies or local health departments, and cost-based reconciliations to non-profit providers and Federally-Qualified Health Centers (FQHCs). We may adjust this definition if expenditures included in the PERM universe are adjusted, as needed, to meet program needs.

III. Collection of Information

Under the Paperwork Reduction Act of 1995 (PRA), we are required to publish a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval.

To fairly evaluate whether an information collection should be approved by OMB, PRA section 3506(c)(2)(A) requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our burden estimates.
- The quality, utility, and clarity of the information to be collected.
- Our effort to minimize the information collection burden on the affected public, including the use of automated collection techniques.

The estimates in this collection of information were derived from feedback received from states during the PERM cycle. We are soliciting public comment on each of the section 3506(c)(2)(A)-required issues for the following information collection requirements (ICRs).

Wages

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2014 National Industry-Specific Occupational Employment and Wage Estimates for State Government (NAICS 999200) (http://www.bls.gov/oes/current/naics4_999200.htm#13-0000). In this regard, Table 1 presents the mean hourly wage, the cost of fringe benefits (calculated at 100 percent of salary), and the adjusted hourly wage.

TABLE 1 (Summary of 2014 BLS State Government Wage Estimates)

Occupation Title	Occupation Code	Mean Hourly Wage (\$/hr)	Fringe Benefit (\$/hr)	Adjusted Hourly Wage
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				(\$/hr)
Claims Adjusters, Appraisers, Examiners, and Investigators	13-1031	\$27.60	\$27.60	\$55.20
Medical Secretaries	43-6013	\$16.50	\$16.50	\$33.00

As indicated, we are adjusting our employee hourly wage estimates by a factor of 100 percent. This is necessarily a rough adjustment, both because fringe benefits and overhead costs vary significantly from employer to employer, and because methods of estimating these costs vary widely from study to study. Nonetheless, there is no practical alternative and we believe that doubling the hourly wage to estimate total cost is a reasonably accurate estimation method.

A. ICRs Regarding Review Procedures(\$431.812)

Section 431.812 would require states to conduct one MEQC pilot during the 2 years between their designated PERM years. Revisions to §431.812, propose that states must use the MEQC pilots to perform both active and negative case reviews, while providing states with some flexibility surrounding their active case review pilot. States would review a minimum total of 400 Medicaid and CHIP active cases, with at least 200 of the active cases being Medicaid cases. States would have the flexibility to determine the precise distribution of active cases (for example, states could sample 300 Medicaid cases and 100 CHIP cases), and states would describe the active sample distribution in the MEQC pilot planning document at §431.814. States would also, at a minimum, be required to review 200 Medicaid and 200 CHIP negative

cases. Currently, under the PERM program, states are required to conduct approximately 200 negative case reviews for each the Medicaid program and CHIP. Therefore, a total minimum negative sample size of 400 (200 for each program) would be reviewed under the MEQC pilots.

Section 431.812 aligns with §431.816 and outlines the case review completion deadlines and submittal of reports. Additionally, §431.820 is also considered to be a part of a state's MEQC pilot reporting. Therefore, burden estimates are combined for the case reviews, the reporting of findings, including corrective actions. The time, effort and costs listed in this section will be identical to the sections where §431.816 and §431.820 are described, but should not be considered additional or separate costs.

The ongoing burden associated with the requirements under §431.812 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP agencies for 17 states equates to a maximum of 34 total respondents each PERM off-year) to perform the required number of eligibility case reviews as mentioned above, and report on their findings and corrective actions.

We estimate that it will take 1,200 hours annually per state program to report on all case review findings (900 hours) and corrective actions (300 hours). This estimate assumes that states spend approximately 100 hours a month on the related activities (100 hours x 12 months = 1,200 hours) during the State's MEQC reporting year. The total estimated annual burden is 40,800 hours (1,200 hours x 34 respondents), at a total estimated cost per respondent of \$66,240 (1,200 hours x (\$55.20/hour)) and a total estimated cost of \$2,252,160 ((\$66,240 per respondent) x 34 respondents) for all respondents. The preceding requirements and burden estimates will be submitted to OMB as a revision to the information collection request currently approved under control number 0938-0147.

B. ICRs Regarding Pilot Planning Document (§431.814)

Revised §431.814 requires states to submit a MEQC Pilot Planning Document. The Pilot Planning Document must be approved by us as outlined in §431.814 of this proposed rule and is critical to ensuring that the state will conduct a MEQC pilot that complies with our guidance. The Pilot Planning Document submitted by the state would include details surrounding how the state will perform both its active and negative case reviews.

The ongoing burden associated with the requirements under §431.814 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP programs for 17 states equates to a maximum of 34 total respondents each PERM off-year) to develop, submit and gain CMS approval of its MEQC Pilot Planning Document.

We estimate that it will take 48 hours per MEQC pilot per state program to submit its Pilot Planning Document and gain approval under §431.814. We have based the estimated 48 hours off of the pilot proposal process currently utilized in the FY2014-2017 Eligibility Review pilots, and have estimated the burden associated accordingly. The total estimated annual burden across all respondents is 1,632 hours ((48 hours/respondent) x 34 respondents). The total estimated cost per respondent is \$2,649.60 (48 hours x (\$55.20/hour)) and the total estimated annual cost across all respondents is \$90,086.40 ((\$2,649.60/respondent) x 34 respondents). As the MEQC program is currently suspended, and will be operationally different under this proposed rule, this estimate is not based on real time data. Once real time data is available, we will solicit information from the states and update our burden estimates accordingly.

The preceding requirements and burden estimates will be submitted to OMB as a revision to the information collection currently approved under control number 0938-0146.

C. ICRs Regarding Case Review Completion Deadlines and Submittal of Reports (§431.816)

Revised §431.816 provides clarification surrounding the case review completion deadlines and submittal of reports. States would be required to report on all sampled cases in a CMS-specified format by August 1 following the end of the MEQC review period.

As mentioned above, §431.816 aligns with sections §431.812 and §431.820, thus, the burden estimates are identical for these sections and should not be thought of as separate estimates or a duplication of effort. The ongoing burden associated with the requirements under §431.816 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP agencies for 17 states equates to maximum 34 total respondents each PERM off-year) to complete the required number of eligibility case reviews, and report on their findings. Refer back to section A. ICRs Regarding Review Procedures (§431.812), for the expanded burden estimate.

The preceding requirements and burden estimates will be submitted to OMB as a revision to the information collection currently approved under control number 0938-0147.

D. ICRs Regarding Corrective Action under the MEQC program (§431.820)

Under the current MEQC program, states are required to conduct corrective actions on all case errors, including technical deficiencies, found through the review. Corrective actions are critical to ensuring that states continually improve and refine their eligibility processes. Therefore, revisions to §431.820 require states to implement corrective actions on any errors or deficiencies identified through the revised MEQC program as outlined under §431.820.

We propose that states report their corrective actions to us by August 1 following completion of the MEQC review period. The report would also include updates on previous corrective actions, including information regarding the status of corrective action implementation and an evaluation of those corrective actions.

The ongoing burden associated with the requirements under §431.820 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP agencies for 17 states equates to maximum 34 total respondents each PERM off-year) to develop and report its corrective actions in response to its MEQC pilot program findings. Refer back to section A. ICRs Regarding Review Procedures (§431.812), for the expanded burden estimate.

The preceding requirements and burden estimates will be submitted to OMB as a revision to the information collection currently approved under control number 0938-0147.

E. ICRs Regarding Information Submission and Systems Access requirements (§431.970)

Currently, the PERM claims component requires state submission of Medicaid and CHIP FFS claims and managed care payments on a quarterly basis; and provider submission of medical records; state and provider submission responsibilities are defined under §431.970. These claims and payments are rigorously reviewed by the federal statistical contractor. We are proposing to utilize this same claims universe to complete the PERM eligibility component. Previously, states had to pull a separate case universe for the PERM eligibility component. With this proposed change, states would only be required to submit one universe to satisfy all components of PERM.

Additionally, states are required to collect and submit (with an estimate of 4 submissions) state policies. With this proposed change, states will still be required to collect and submit state policies surrounding FFS and managed care, but would now also have to submit all state eligibility policies. There would be an initial submission and quarterly updates. There are no proposed changes for the provider submission of medical records.

The ongoing burden associated with the requirements under §431.970 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP agencies for 17 states equates to maximum 34 total respondents each PERM year) to submit its claims universe,

and collect and submit state policies, and the time and effort it would take providers to furnish medical record documentation.

We estimate that it will take 1,350 hours annually per state program to develop and submit its claims universe and state policies. The total estimated hours is broken down between the FFS, managed care, and eligibility components and is estimated at 900 hours for universe development and submission, and 450 hours for policy collection and submission. Per component it is estimated at 1,150 FFS hours, 100 managed care hours, 100 eligibility hours for a total of 45,900 annual hours (1,350 hours x 34 respondents). The total estimated annual cost per respondent is \$74,520 (1,350 hours x (\$55.20/hour), and the total estimated annual cost across all respondents is \$2,533,680 ((\$74,520/respondent) x 34 respondents).

However, as a federal contractor has not previously conducted the eligibility component of PERM, the hours assessed related to the state burden associated with the revised eligibility component are not based on real time data, but rather based off information solicited from the states. The information received was from those states who participated in the PERM model eligibility pilots which were conducted by a federal contractor, but on a much smaller scale than that of PERM.

The preceding requirements and burden estimates will be submitted to OMB as a revision to the information collection currently approved under control numbers 0938-0974, 0938-0994, and 0938-1012.

We estimate that it will take 2,824 hours annually per program for providers to furnish medical record documentation to substantiate claim submission. These estimates are based on the average number of medical reviews conducted per PERM cycle and the average amount of time it takes for providers to comply with the medical record request. These estimates are for FFS

claims only, as medical review is only completed on sampled FFS claims. The total estimated cost for annual submission is \$93,192 (2,824 hours/program) x (\$16.50/hour).

F. ICRs Regarding Corrective Action Plan under the PERM program (§431.992)

Currently, under §431.992, states are required to submit corrective action plans to address all improper payments and deficiencies found through the PERM review. Proposed revisions to §431.992(a) clarify that states would be required to address all improper payments and deficiencies included in the state improper payment rate as defined at §431.960(f)(1). Additional language was also added to §431.992 to clarify the state responsibility to evaluate corrective actions from the previous PERM cycle at §431.992(b)(4).

The ongoing burden associated with the requirements under §431.992 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP agencies for 17 states equates to maximum 34 total respondents per PERM cycle) to submit its corrective action plan.

We estimate that it will take 750 hours (250 hours for FFS, 250 hours for managed care and an additional 250 hours for eligibility), per PERM cycle per state program to submit its corrective action plan for a total estimated annual burden of 25,500 hours ((750 hours/respondent) x 34 respondents). We estimate the total cost per respondent to be \$41,400 (750 hours x (\$55.20/hour)). The total estimated cost for all respondents is \$1,407,600 (((\$41,400/respondent) x 34 respondents).

However, as a federal contractor has not previously conducted the eligibility component of PERM, the hours assessed related to the state burden associated with the revised eligibility component are not based on real time data, but rather based off information solicited from the states. The information received was from those states who participated in the PERM model

eligibility pilots which were conducted by a federal contractor, but on a much smaller scale than that of PERM.

The preceding requirements and burden estimates will be submitted to OMB as part of revisions to the information collections currently approved under control numbers 0938-0974, 0938-0994 and 0938-1012. Not to be confused with the burden set outlined above, the revised PERM PRA packages' total burden would amount to: 34 annual respondents, 34 annual responses, and 750 hours per corrective action plan.

G. ICRs Regarding Difference Resolution and Appeal Process (§431.998)

Currently, the difference resolution and appeals process used for the FFS and managed care components of the PERM program is well developed and has allowed us to adequately resolve disagreements between the RC and states. Revisions to §431.998 now include the proposed eligibility changes for the difference resolution and appeals process. Because we propose to use an ERC to conduct the eligibility case reviews, we likewise propose that the ERC conduct the eligibility difference resolution and appeals process, which would mirror how that process is conducted with respect to FFS claims and managed care payments.

The ongoing burden associated with the requirements under §431.998 is the time and effort it would take each of the 34 state programs (17 Medicaid and 17 CHIP agencies for 17 states equates to maximum 34 total respondents per PERM cycle) to review PERM findings and inform the federal contractor(s) of any additional information and/or dispute requests.

We estimate that it will take 1625 hours (500 hours for FFS, 475 hours for managed care and an additional 650 hours for eligibility) per PERM cycle per state program to review PERM findings and inform federal contractor(s) of any additional information or dispute requests for FFS, managed care, and eligibility components total estimated annual burden of 55,250 hours ((1,625 hours/respondent) x 34 respondents). We estimate the total cost per respondent to be

\$89,700 (1,625 hours x (\$55.20/hour)). The total estimated cost for all respondents is \$3,049,800 (((\$89,700/respondent) x 34 respondents).

The preceding requirements and burden estimates will be submitted to OMB as revisions to the information collections currently approved under control numbers 0938-0974, 0938-0994, and 0938-1012. Not to be confused with the burden set outlined above, the revised PERM PRA packages' total burden would amount to: 34 annual respondents, 34 annual responses, and 1,625 hours per PERM cycle.

TABLE 2: Summary of Annual Information Collection Burden Estimates

Regulation Section(s)	OCN	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting (\$)	Total Cost (\$)
§431.812	0938-0147	34	34	1,200	40,800	\$66,240.00	\$2,252,160.00
§431.814	0938-0146	34	34	48	1,632	\$2,649.60	\$90,086.40
§431.816	0938-0147	34	34*	1,200*	40,800*	\$66,240.00*	\$2,252,160.00*
§431.820	0938-0147	34	34*	1,200*	40,800*	\$66,240.00*	\$2,252,160.00*
§431.970	0938-0974; 0938-0994; 0938-1012	34	34	1,350	51,548**	\$167,712.00**	\$2,626,872.00**
§431.992	0938-0974; 0938-0994; 0938-1012	34	34	750	25,500	\$41,400.00	\$1,407,600.00
§431.998	0938-0974;	34	34	1,625	55,250	\$89,700.00	\$3,049,800.00

Regulation Section(s)	OCN	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting (\$)	Total Cost (\$)
	0938- 0994; 0938- 1012						
Total	--	34	170	--	174,330	\$367,701.60	\$9,426,518.40

*Not included in totals, as these represent the combined estimated hours/cost for 3 sections as mentioned above. These numbers should only be counted once.

**The total annual hours and cost for provider submissions are included in these numbers. Due to the variability in the number of providers providing responses these numbers were not included in the total hours.

Submission of PRA-Related Comments

We have submitted a copy of this proposed rule to OMB for its review of the rule's information collection and recordkeeping requirements. These requirements are not effective until they have been approved by the OMB.

To obtain copies of the supporting statement and any related forms for the proposed collections discussed above, please visit CMS' Website at www.cms.hhs.gov/PaperworkReductionActof1995, or call the Reports Clearance Office at 410-786-1326.

We invite public comments on these potential information collection requirements. If you wish to comment, please submit your comments electronically as specified in the ADDRESSES section of this proposed rule and identify the rule (CMS-6068-P) the ICR's CFR citation, CMS ID number, and OMB control number.

ICR-related comments are due [INSERT DATE 60-DAYS AFTER THE DATE OF PUBLICATION IN THE FEDERAL REGISTER.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the DATES section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Statement

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96 354), section 1102(b) of the Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999) and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects (\$100 million or more in any 1 year). This proposed rule would make small changes to the administration of the existing MEQC and PERM programs. It would therefore have a relatively small economic impact; as a result, this proposed rule does not reach the \$100 million threshold and thus is neither an “economically significant” rule under E.O. 12866, nor a “major rule” under the Congressional Review Act.

The Regulatory Flexibility Act requires agencies to analyze options for regulatory relief of small entities, and to prepare an Initial Regulatory Flexibility Analysis (IRFA), for proposed rules that would have a “significant economic impact on a substantial number of small entities.” For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.5 million to \$38.5 million in any 1 year. Individuals and states are not included in the definition of a small entity. These entities may incur costs due to collecting and submitting medical records to support medical reviews, but we estimate that these costs would not be significantly changed under the proposed rule. Therefore, we are not preparing an IRFA because we have determined that this proposed rule would not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a metropolitan statistical area and has fewer than 100 beds. For the preceding reasons, we are not preparing an analysis for section 1102(b) of the Act because we have determined that this proposed rule would not have a direct economic impact on the operations of a substantial number of small rural hospitals.

Please note, a state will be reviewed only once, per program, every 3 years and it is unlikely for a provider to be selected more than once per program to provide supporting documentation.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of \$100 million in 1995 dollars, updated annually for inflation. In 2016, that threshold is approximately \$146 million. For the preceding reasons, we have determined that this proposed rule does not mandate any spending that would approach the \$146 million threshold for state, local, or tribal governments, or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it issues a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on state and local governments, preempts state law, or otherwise has Federalism implications. This proposed rule would shift minor costs and burden for conducting PERM eligibility reviews from states to the federal government and its contractors. However, these reductions would be largely offset by federal government savings in reduced payments to states in matching funds. The net effect of this proposed regulation on state or local governments is minor.

PERM calculates national level improper payment estimates as required by IPERIA as well as state level improper payment estimates. The impacts of this rule are based on the proposed approach to continue meeting national level precision requirements and striving to obtain a state level precision goal. In the most recent PERM cycle, 13,392 Medicaid FFS claims; 9,416 CHIP FFS claims; 3,360 Medicaid managed care payments; and 2,880 CHIP managed care payments are being sampled for review. If we were to alternatively set state sample sizes to guarantee increased state level improper payment rate precision, we would need to review a much higher number of claims in a cycle.

For example, to guarantee state level improper payment rate precision within 3 percentage points we estimate, based on previous cycle sample data, that we would need to

review nearly 100,000 Medicaid FFS claims for the cycle (in comparison to the currently reviewed 13,392). Under alternative state level precision goals, for example, 3 percentage points for the top three expenditure states and 5 percentage points in the remaining 14 states in a PERM cycle, we estimate, based on previous sampling data, that PERM would need to review close to 40,000 Medicaid FFS claims for the cycle (in comparison to the currently reviewed 13,392). While such approaches would ensure state level improper payment rate precision, they would also yield operational, budgetary, feasibility, and state burden concerns.

Although we do not expect in the final rulemaking to commit to a particular sample size in future years, we welcome public comments that may inform the general approach we take to sampling and factors that we should consider in establishing state sample sizes.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the OMB.

List of Subjects42 CFR Part 431

Grant programs-health, Health facilities, Medicaid, Privacy, Reporting and recordkeeping requirements.

42 CFR Part 457

Grant programs-health, Health insurance, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 431—STATE ORGANIZATION AND GENERAL ADMINISTRATION

1. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act, (42 U.S.C. 1302).

2. Sections 431.800 and the undesignated center heading preceding §431.800 are revised to read as follows:

MEDICAID ELIGIBILITY QUALITY CONTROL (MEQC) PROGRAM

§431.800 Basis and scope.

This subpart establishes State requirements for the Medicaid Eligibility Quality Control (MEQC) Program designed to reduce erroneous expenditures by monitoring eligibility determinations and a claims processing assessment that monitors claims processing operations. MEQC will work in conjunction with the Payment Error Rate Measurement (PERM) Program established in subpart Q of this part. In years in which the State is required to participate in PERM, as stated as in subpart Q, States will only participate in the PERM program and will not be required to conduct a MEQC pilot. In the 2 years between PERM cycles, states are required to conduct a MEQC pilot, as set forth in this subpart.

3. Section 431.804 is revised to read as follows:

§431.804 Definitions.

As used in this subpart—

Active case means an individual determined to be currently authorized as eligible for Medicaid or CHIP by the State.

Corrective action means action(s) to be taken by the State to reduce major error causes, trends in errors or other vulnerabilities for the purpose of reducing improper payments in Medicaid and CHIP.

Deficiency means a finding in which a claim or payment had a medical, data processing, and/or eligibility error that did not result in Federal and/or State improper payment.

Eligibility means meeting the State's categorical and financial criteria for receipt of benefits under the Medicaid or CHIP programs.

Eligibility error is an error resulting from the States' improper application of Federal rules and the State's documented policies and procedures that causes a beneficiary to be determined eligible when he or she is ineligible for Medicaid or CHIP, causes a beneficiary to be determined eligible for the incorrect type of assistance, causes applications for Medicaid or CHIP to be improperly denied by the State, or causes existing cases to be improperly terminated from Medicaid or CHIP by the State. An eligibility error may also be caused when a redetermination did not occur timely or a required element of the eligibility determination process (for example income) cannot be verified as being performed/completed by the state.

Medicaid Eligibility Quality Control (MEQC) means a program designed to reduce erroneous expenditures by monitoring eligibility determinations and work in conjunction with the PERM program established in subpart Q of this part.

MEQC Pilot refers to the process used to implement the MEQC Program.

MEQC review period is the 12-month timespan from which the State will sample and review cases.

Negative case means an individual denied or terminated eligibility for Medicaid or CHIP by the State.

Off-years are the scheduled 2-year period of time between a States' designated PERM years.

Payment Error Rate Measurement (PERM) program means the program set forth at subpart Q utilized to calculate a national improper payment rate.

PERM year is the scheduled and designated year for a State to participate in and be measured by the PERM program set forth at subpart Q of this part.

4. Section 431.806 is revised to read as follows:

§431.806 State requirements.

(a) General requirements. (1) In a State's PERM year, the PERM measurement will meet the requirements of section 1903(u) of the Act.

(2) In the 2 years between each State's PERM year, States are required to conduct one MEQC pilot, which will span parts of both off years.

(i) The MEQC pilot review period will span 12-months of a calendar year, beginning the January 1 following the end of the State's PERM year through December 31.

(ii) The MEQC pilot planning document described in §431.814 is due no later than the first November 1 following the end of the State's PERM year.

(iii) States must submit their MEQC pilot findings and their plan for corrective action(s) by the August 1 following the end of their MEQC pilot review period.

(b) PERM measurement. Requirements for the State PERM review process are set forth in subpart Q.

(c) MEQC pilots. MEQC pilot requirements are specified in §§431.812 through 431.820.

(d) Claims processing assessment system. Except in a State that has an approved Medicaid Management Information System (MMIS) under subpart C of part 433 of this

subchapter, a State plan must provide for operating a Medicaid quality control claims processing assessment system that meets the requirements of §§431.830 through 431.836.

5. The undesignated center heading preceding §431.810 is removed and §431.810 is revised to read as follows:

§431.810 Basic elements of the Medicaid Eligibility Quality Control (MEQC) Program

(a) General requirements. The State must operate the MEQC pilot in accordance with this section and §§431.812 through 431.820 as well as other instructions established by CMS.

(b) Review requirements. The State must conduct reviews for the MEQC pilot in accordance with the requirements specified in §431.812 and other instructions established by CMS.

(c) Pilot planning requirements. The State must develop a MEQC pilot planning proposal in accordance with requirements specified in §431.814 and other instructions established by CMS.

(d) Reporting requirements. The State must report the finding of the MEQC pilots in accordance with the requirements specified in §431.816 and other instructions established by CMS.

(e) Corrective action requirements. The State must conduct corrective actions based on the findings of the MEQC pilots in accordance with the requirements specified in §431.820 and other instructions established by CMS.

6. Section 431.812 is revised to read as follows:

§431.812 Review procedures.

(a) General requirements. Each state is required to conduct a MEQC pilot during the 2 years between required PERM cycles in accordance with the approved pilot planning document specified in §431.814, as well as other instructions established by CMS. The agency and

personnel responsible for the development, direction, implementation, and evaluation of the MEQC reviews and associated activities, must be functionally and physically separate from the State agencies and personnel that are responsible for Medicaid and CHIP policy and operations, including eligibility determinations.

(b) Active case reviews. (1) The State must review all active cases selected from the universe of cases, as established in the state's approved MEQC pilot planning document, under §431.814 to determine if the cases were eligible for services, as well as to identify deficiencies in processing subject to corrective actions.

(2) The State must select and review, at a minimum, 400 active cases in total from the Medicaid and CHIP universe.

(i) The State must review at least 200 Medicaid cases.

(ii) The State will identify in the pilot planning document at §431.814 the sample size per program.

(iii) A State may sample more than 400 cases.

(3) The State may propose to focus the active case reviews on recent changes to eligibility policies and processes, areas where the state suspects vulnerabilities, or proven error prone areas.

(i) The State must propose its active case review approach, unless otherwise directed by CMS, in the pilot planning document described at §431.814 or perform a comprehensive review.

(ii) The State must follow CMS direction for its active case reviews, when the State has a PERM eligibility improper payment rate that exceeds the 3 percent national standard for two consecutive PERM cycles. CMS guidance will be provided to any state meeting this criteria.

(c) Negative case reviews. (1) The State must review negative cases selected from the State's universe of cases, as established in the State's approved MEQC pilot planning document

under §431.814, that are denied or terminated in the review month to determine if the denial, or termination was correct as well as to identify deficiencies in processing subject to corrective actions.

(2) The State must review, at a minimum, 200 negative cases from Medicaid and 200 negative cases from CHIP.

(i) A states may sample more than 200 cases from Medicaid and/or more than 200 cases from CHIP.

(ii) [Reserved]

(d) Error definition. (1) An active case error is an error resulting from the State's improper application of Federal rules and the State's documented policies and procedures that causes a beneficiary to be determined eligible when he or she is ineligible for Medicaid or CHIP, causes a beneficiary to be determined eligible for the incorrect type of assistance, or when a determination did not occur timely or cannot be verified.

(2) Negative case errors are errors, based on the State's documented policies and procedures, resulting from either of the following:

(i) Applications for Medicaid or CHIP that are improperly denied by the State.

(ii) Existing cases that are improperly terminated from Medicaid or CHIP by the State.

(e) Active case payment reviews. In accordance with instructions established by CMS, States must also conduct payment reviews to identify payments for active case errors, as well as identify the individual's understated or overstated liability, and report payment findings as specified in §431.816.

7. Section 431.814 is revised to read as follows:

§431.814 Pilot planning document.

(a) Plan approval. For each MEQC pilot, the state must submit a MEQC pilot planning document that meets the requirements of this section to CMS for approval by the first November 1 following the end of the State's PERM year. The State must receive approval for a plan before the plan can be implemented.

(b) Plan requirements. The State must have an approved pilot planning document in effect for each MEQC pilot that must be in accordance with instructions established by CMS and that includes, at a minimum, the following for—

(1) Active case reviews. (i) Focus of the active case reviews in accordance with §431.812(b)(3).

(ii) Universe development process.

(iii) Sample size per program.

(iv) Sample selection procedure.

(v) Case review process.

(2) Negative case reviews. (i) Universe development process.

(ii) Sample size per program.

(iii) Sample selection procedure.

(iv) Case review process.

8. Section 431.816 is revised to read as follows:

§431.816 Case review completion deadlines and submittal of reports.

(a) The State must complete case reviews and submit reports of findings to CMS as specified in paragraph (b) of this section in the form and at the time specified by CMS.

(b) In addition to the reporting requirements specified in §431.814 relating to the MEQC pilot planning document, the State must complete case reviews and submit reports of findings to CMS in accordance with paragraphs (b)(1) and (2) of this section.

(1) For all active and negative cases reviewed, the State must submit a detailed case-level report in a format provided by CMS.

(2) All case-level findings will be due by August 1 following the end of the MEQC review period.

9. Section 431.818 is revised to read as follows:

§431.818 Access to records.

The State, upon written request, must submit to the HHS staff, or other designated entity, all records, including complete local agency eligibility case files or legible copies and all other documents pertaining to its MEQC reviews to which the State has access, including information available under part 435, subpart I of this chapter.

10. Section 431.820 is revised to read as follows:

§431.820 Corrective action under the MEQC program.

The state must—

(a) Take action to correct any active or negative case errors, including deficiencies, found in the MEQC pilot sampled cases in accordance with instructions established by CMS;

(b) By the August 1 following the MEQC review period, submit to CMS a report that—

(1) Identifies the root cause and any trends found in the case review findings.

(2) Offers corrective actions for each unique error and deficiency finding based on the analysis provided in paragraph (b)(1) of this section.

(c) In the corrective action report, the state must provide updates on corrective actions reported for the previous MEQC pilot.

§431.822 [Removed]

11. Section 431.822 is removed.

§§431.861 – 431.865 [Removed]

12. The undesignated center heading “Federal Financial Participation” and §§431.861 through 431.865 are removed.

13. Section 431.950 is revised to read as follows:

§431.950 Purpose.

This subpart requires States and providers to submit information and provide support to Federal contractors as necessary to enable the Secretary to produce national improper payment estimates for Medicaid and the Children's Health Insurance Program (CHIP).

14. Section 431.958 is amended by—

- a. Removing the definitions of “Active case”, “Active fraud investigation”, and “Agency”.
- b. Revising the definition of “Annual sample size”.
- c. Adding a definition in alphabetical order for “Appeals”,
- d. Removing the definitions of “Application”, “Case”, “Case error rate”, and “Case record”.
- e. Adding definitions in alphabetical order for “Corrective action”, “Deficiency”, “Difference resolution”, “Disallowance”, “Eligibility Review Contractor (ERC)”, “Error”, “Federal Contractor”, “Federally Facilitated Marketplace (FFM)”, “Federally Facilitated Marketplace-Determination (FFM-D)”, “Federal financial participation”, “Finding”, and “Improper payment rate”.
- f. Removing the definition of “Last action”.
- g. Adding a definition in alphabetical order for “Lower limit”.
- h. Removing the definitions of “Negative case”, “Payment error rate”, and “Payment review”.
- i. Adding definitions in alphabetical order for “PERM Review Period” and “Recoveries”,

- j. Adding a definition in alphabetical order for “Review Contractor (RC)”.
- k. Removing the definitions of “Review cycle” and “Review month”.
- l. Revising the definition of “Review year”.
- m. Removing the definitions of “Sample month” and “State agency”.
- n. Adding a definition in alphabetical order for “State eligibility system”.
- o. Revising the definition of “State error”.
- p. Adding definitions in alphabetical order for “State payment system”, “State-specific sample size”, and “Statistical Contractor (SC).”
- q. Removing the definition of “Undetermined”.

The additions and revisions read as follows:

§431.958 Definitions and use of terms.

* * * * *

Annual sample size means the number of fee-for-service claims, managed care payments, or eligibility cases that will be sampled for review in a given PERM cycle

Appeals means a process that allows states to dispute the PERM Review Contractor and Eligibility Review Contractor error findings with CMS after the difference resolution process has been exhausted.

* * * * *

Corrective action means actions to be taken by the state to reduce major error causes, trends in errors, or other vulnerabilities for the purpose of reducing improper payments in Medicaid and CHIP.

* * * * *

Deficiency means a finding in which a claim or payment had a medical, data processing, and/or eligibility error that did not result in federal and/or state improper payment.

Difference resolution means a process that allows states to dispute the PERM Review Contractor and Eligibility Review Contractor error findings directly with the contractor.

Disallowance means the percentage of Federal Medicaid funds States are required to return to CMS in accordance with section 1903(u) of the Act.

* * * * *

Eligibility Review Contractor (ERC) means the CMS contractor responsible for conducting state eligibility reviews for PERM.

Error means any claim or payment where federal and/or state dollars were paid improperly based on medical, data processing, and/or eligibility reviews.

* * * * *

Federal Contractor means the ERC, RC, or SC which support CMS in executing the requirements of the PERM program.

Federally Facilitated Marketplace (FFM) means the health insurance exchange established by the Federal government with responsibilities that include making Medicaid and CHIP determinations for states that delegate authority to the FFM.

Federally Facilitated Marketplace - Determination (FFM-D) means cases determined by the FFM in states that have delegated the authority to make Medicaid/CHIP eligibility determinations to the FFM.

Federal financial participation means the Federal Government's share of a State's expenditures under the Medicaid program and CHIP.

Finding means errors and/or deficiencies identified through the medical, data processing, and eligibility reviews.

Improper payment rate means an annual estimate of improper payments made under Medicaid and CHIP equal to the sum of the overpayments and underpayments in the sample, that

is, the absolute value of such payments, expressed as a percentage of total payments made in the sample.

Lower limit means the lower bound of the 95-percent confidence interval for a state's eligibility improper payment rate.

* * * * *

PERM review period means the timeframe in which claims and eligibility are reviewed for national annual improper payment rate calculation purposes, July through June.

* * * * *

Recoveries mean those monies that states are responsible for payment back to CMS based on the identification of Federal improper payments.

Review Contractor (RC) means the CMS contractor responsible for conducting state data processing and medical record reviews for PERM.

Review year means the year being analyzed for improper payments under PERM.

* * * * *

State eligibility system means any system, within the state or with a state-delegated contractor, that is used by the state to determine Medicaid and/or CHIP eligibility and/or that maintains documentation related to Medicaid and/or CHIP eligibility determinations.

State error includes, but is not limited to, data processing errors and eligibility errors as described in §431.960(b) and (d), as determined in accordance with documented State and Federal policies. State errors do not include the errors described in paragraph §431.960(e)(2).

State payment system means any system within the state or with a state-delegated contractor that is used to adjudicate and pay Medicaid and/or CHIP FFS claims and/or managed care payments.

State-specific sample size means the sample size determined by CMS that is required from each individual States to support national improper payment rate precision requirements.

Statistical Contractor (SC) means the contractor responsible for collecting and sampling fee-for-service claims and managed care capitation payment data as well as calculating state and national improper payment rates.

* * * * *

15. Section 431.960 is revised to read as follows:

§431.960 Types of payment errors.

(a) General rule. Errors identified for the Medicaid and CHIP improper payments measurement under the Improper Payments Information Act of 2002 must affect payment under applicable Federal policy or State policy or both.

(b) Data processing errors. (1) A data processing error is an error resulting in an overpayment or underpayment that is determined from a review of the claim and other information available in the State's Medicaid Management Information System, related systems, or outside sources of provider verification resulting in Federal and/or State improper payments.

(2) The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with federal and state documented policies, is the dollar measure of the payment error.

(3) Data processing errors include, but are not limited to the following:

- (i) Payment for duplicate items.
- (ii) Payment for non-covered services.
- (iii) Payment for fee-for-service claims for managed care services.
- (iv) Payment for services that should have been paid by a third party but were inappropriately paid by Medicaid or CHIP.
- (v) Pricing errors.
- (vi) Logic edit errors.
- (vii) Data entry errors.

(viii) Managed care rate cell errors.

(ix) Managed care payment errors.

(c) Medical review errors. (1) A medical review error is an error resulting in an overpayment or underpayment that is determined from a review of the provider's medical record or other documentation supporting the service(s) claimed, Code of Federal Regulations that are applicable to conditions of payment, the State's written policies, and a comparison between the documentation and written policies and the information presented on the claim resulting in Federal and/or State improper payments.

(2) The difference in payment between what the State paid (as adjusted within improper payment measurement guidelines) and what the State should have paid, in accordance with 42 CFR parts 440 through 484 in accordance with the applicable conditions of payment in this chapter and the State's documented policies is the dollar measure of the payment error.

(3) Medical review errors include, but are not limited to the following:

(i) Lack of documentation.

(ii) Insufficient documentation.

(iii) Procedure coding errors.

(iv) Diagnosis coding errors.

(v) Unbundling.

(vi) Number of unit errors.

(vii) Medically unnecessary services.

(viii) Policy violations.

(ix) Administrative errors.

(d) Eligibility errors. (1) An eligibility error is an error resulting in an overpayment or underpayment that is determined from a review of a beneficiary's eligibility determination, in

comparison to the documentation used to establish a beneficiary's eligibility and applicable federal and state regulations and policies, resulting in Federal and/or State improper payments.

(2) Eligibility errors include, but are not limited to the following:

(i) Ineligible individual, but authorized as eligible when he or she received services.

(ii) Eligible individual for the program, but was ineligible for certain services he or she received.

(iii) Lacked or had insufficient documentation in his or her case record, in accordance with the State's documented policies and procedures, to make a definitive review decision of eligibility or ineligibility.

(iv) Was ineligible for managed care but enrolled in managed care.

(3) The dollars paid in error due to the eligibility error is the measure of the payment error.

(4) A State eligibility error does not result from the State's verification of an applicant's self-declaration or self-certification of eligibility for, and the correct amount of, medical assistance or child health assistance, if the State process for verifying an applicant's self-declaration or self-certification satisfies the requirements in Federal law, guidance, or if applicable, Secretary approval.

(e) Errors for purposes of determining the national improper payment rates. (1) The Medicaid and CHIP national improper payment rates include but are not limited to the errors described in paragraphs (b) through (d) of this section.

(2) Eligibility errors resulting solely from determinations of Medicaid or CHIP eligibility delegated to and made by the Federally Facilitated Marketplace will be included in the national improper payment rate.

(f) Errors for purposes of determining the State improper payment rates. (1) The Medicaid and CHIP State improper payment rates include but are not limited to, the errors described in paragraphs (b) through (d) of this section, and do not include the errors described in paragraph (e)(2) of this section.

(g) Error codes. CMS will define different types of errors within the above categories for analysis and reporting purposes. Only Federal and/or State dollars in error will factor into a State's PERM improper payment rate.

16. Section 431.970 is revised to read as follows:

§431.970 Information submission and systems access requirements.

(a) States must submit information to the Secretary for, among other purposes, estimating improper payments in Medicaid and CHIP, that include but are not limited to—

- (1) Adjudicated fee-for-service or managed care claims information or both, on a quarterly basis, from the review year;
- (2) Upon request from CMS, provider contact information that has been verified by the State as current;
- (3) All medical, eligibility, and other related policies in effect and any quarterly policy updates;
- (4) Current managed care contracts, rate information, and any quarterly updates applicable to the review year;
- (5) Data processing systems manuals;
- (6) Repricing information for claims that are determined during the review to have been improperly paid;
- (7) Information on claims that were selected as part of the sample, but changed in substance after selection, for example, successful provider appeals;

(8) Adjustments made within 60 days of the adjudication dates for the original claims or line items with sufficient information to indicate the nature of the adjustments and to match the adjustments to the original claims or line items;

(9) Case documentation to support the eligibility review, as requested by CMS;

(10) A corrective action plan for purposes of reducing erroneous payments in FFS, managed care, and eligibility; and

(11) Other information that the Secretary determines is necessary for, among other purposes, estimating improper payments and determining improper payment rates in Medicaid and CHIP.

(b) Providers must submit information to the Secretary for, among other purposes estimating improper payments in Medicaid and CHIP, which include but are not limited to Medicaid and CHIP beneficiary medical records, within 75 calendar days of the date the request is made by CMS. If CMS determines that the documentation is insufficient, providers must respond to the request for additional documentation within 14 calendar days of the date the request is made by CMS.

(c) The State must provide the Federal contractor(s) with access to all payment system(s) necessary to conduct the medical and data processing review, including the Medicaid Management Information System (MMIS), any systems that include beneficiary demographic and/or provider enrollment information, and any document imaging systems that store paper claims.

(d) The State must provide the Federal contractor(s) with access to all eligibility system(s) necessary to conduct the eligibility review, including any eligibility systems of record, any electronic document management system(s) that house case file information, and systems that house the results of third party data matches.

17. Section 431.972 is revised to read as follows:

§431.972 Claims sampling procedures.

(a) General requirements. States will submit quarterly FFS claims and managed care payments, as identified in §431.970(a), to allow federal contractors to conduct data processing, medical record, and eligibility reviews to meet the requirements of the PERM measurement.

(b) Claims universe. (1) The PERM claims universe includes payments that were originally paid (paid claims) and for which payment was requested but denied (denied claims) during the PERM review period, and for which there is FFP (or would have been if the claim had not been denied) through Title XIX (Medicaid) or Title XXI (CHIP).

(2) The State must establish controls to ensure FFS and managed care universes are accurate and complete, including comparing the FFS and managed care universes to the Form CMS-64 and Form CMS-21 as appropriate.

(c) Sample size. CMS estimates a State's annual sample size for the PERM review at the beginning of the PERM cycle.

(1) Precision and confidence levels. The national annual sample size will be estimated to achieve at least a minimum National-level improper payment rate with a 90 percent confidence interval of plus or minus 2.5 percent of the total amount of all payments for Medicaid and CHIP.

(2) State-specific sample sizes. CMS will develop State-specific sample sizes for each state. CMS may take into consideration the following factors in determining a State's annual state-specific sample size for the current PERM cycle: State-level precision goals for the current PERM cycle; the improper payment rate and precision of that improper payment rate from the State's previous PERM cycle; the State's overall Medicaid and CHIP expenditures; and other relevant factors as determined by CMS.

§431.974 [Removed]

18. Section 431.974 is removed.

§431.978 [Removed]

19. Section 431.978 is removed.

§431.980 [Removed]

20. Section 431.980 is removed.

§431.988 [Removed]

21. Section 431.988 is removed.

22. Section 431.992 is revised to read as follows:

§431.992 Corrective action plan.

(a) The State must develop a separate corrective action plan for Medicaid and CHIP for each improper payment rate measurement, designed to reduce improper payments in each program based on its analysis of the improper payment causes in the FFS, managed care, and eligibility components.

(1) The corrective action plan must address all errors that are included in the state improper payment rate defined at §431.960(f)(1) and all deficiencies.

(2) [Reserved]

(b) In developing a corrective action plan, the State must take the following actions:

(1) Error analysis. States must conduct analysis such as reviewing causes, characteristics, and frequency of errors that are associated with improper payments. States must review the findings of the analysis to determine specific programmatic causes to which errors are attributed (for example, provider lack of understanding of the requirement to provide documentation), if any, and to identify root improper payment causes.

(2) Corrective action planning. States must determine the corrective actions to be implemented that address the root improper payment causes and prevent that same improper payment from occurring again.

(3) Implementation and monitoring. (i) States must develop an implementation schedule for each corrective action and implement those actions in accordance with the schedule.

(ii) The implementation schedule must identify all of the following for each action:

(A) The specific corrective action.

(B) Status.

(C) Scheduled or actual implementation date.

(D) Key personnel responsible for each activity.

(E) A monitoring plan for monitoring the effectiveness of the action.

(4) Evaluation. The State must submit an evaluation of the corrective action plan from the previous measurement. States must evaluate the effectiveness of the corrective action(s) by assessing all of the following:

(i) Improvements in operations.

(ii) Efficiencies.

(iii) Number of errors.

(iv) Improper payments.

(v) Ability to meet the PERM improper payment rate targets assigned by CMS.

(c) The State must submit to CMS and implement the corrective action plan for the fiscal year it was reviewed no later than 90 calendar days after the date on which the State's Medicaid or CHIP improper payment rates are posted on the CMS contractor's website.

(d) The State must provide updates on corrective action plan implementation progress annually and upon request by CMS.

(e) In addition to paragraphs (a) through (d) of this section, States that have eligibility improper payment rates over the allowable threshold of 3 percent for consecutive PERM years, must submit updates on the status of corrective action implementation to CMS every other month. Status updates must include, but are not limited to the following:

- (1) Details on any setbacks along with an alternate corrective action or workaround.
- (2) Actual examples of how the corrective actions have led to improvements in operations, and explanations for how the improvements will lead to a reduction in the number of errors, as well as the state's next PERM eligibility improper payment rate.
- (3) An overall summary on the status of corrective actions, planning, and implementation, which demonstrates how the corrective actions will provide the state with the ability to meet the 3 percent threshold.

23. Section 431.998 is revised to read as follows:

§431.998 Difference resolution and appeal process.

(a) The State may file, in writing, a request with the relevant Federal contractor to resolve differences in the Federal contractor's findings based on medical, data processing, or eligibility reviews in Medicaid or CHIP.

(b) The State must file requests to resolve differences based on the medical, data processing, or eligibility reviews within 20 business days after the report of review findings is shared with the state.

(c) To file a difference resolution request, the State must be able to demonstrate all of the following:

- (1) Have a factual basis for filing the request.
- (2) Provide the appropriate Federal contractor with valid evidence directly related to the finding(s) to support the State's position.

(d) For a finding in which the State and the Federal contractor cannot resolve the difference in findings, the State may appeal to CMS for final resolution by filing an appeal within 10 business days from the date the relevant Federal contractor's finding as a result of the difference resolution is shared with the State. There is no minimum dollar threshold required to appeal a difference in findings.

(e) To file an appeal request, the State must be able to demonstrate all of the following:

(1) Have a factual basis for filing the request.

(2) Provide CMS with valid evidence directly related to the finding(s) to support the State's position.

(f) All differences, including those pending in CMS for final decision that are not overturned in time for improper payment rate calculation, will be considered as errors in the improper payment rate calculation in order to meet the reporting requirements of the IPIA.

24. Section 431.1010 is added to read as follows:

§431.1010 Disallowance of Federal financial participation for erroneous State payments (for PERM review years ending after July 1, 2020).

(a) Purpose) This section establishes rules and procedures for disallowing Federal financial participation (FFP) in erroneous medical assistance payments due to eligibility improper payment errors, as detected through the PERM program required under this subpart, in effect on and after July 1, 2020.

(2) After the State's eligibility improper rate has been established for each PERM review period, CMS will compute the amount of the disallowance and adjust the FFP payable to each State.

(3) CMS will compute the amount to be withheld or disallowed as follows:

(i) Subtract the 3 percent allowable threshold from the lower limit of the State's eligibility improper payment rate percentage.

(ii) If the difference is greater than zero, the Federal medical assistance funds for the period, are multiplied by that percentage. This product is the amount of the disallowance or withholding.

(b) Notice to States and showing of good faith. (1) If CMS is satisfied that the State did not meet the 3 percent allowable threshold despite a good faith effort, CMS will reduce the funds being disallowed in whole.

(2) CMS may find that a State did not meet the 3 percent allowable threshold despite a good faith effort if the State has taken the action it believed was needed to meet the threshold, but the threshold was not met. CMS will grant a good faith waiver only if a state both:

(i) Participates in the MEQC pilot program in accordance with subpart P (§431.800 through §431.820), and

(ii) Implements PERM CAPs in accordance with §431.992.

(3) States that have improper payment rates above the allowable threshold will be notified by CMS of the amount of the disallowance.

(c) Disallowance subject to appeal. If a State does not agree with a disallowance imposed under paragraph (e) of this section, it may appeal to the Departmental Appeals Board within 30 days from the date of the final disallowance notice from CMS. The regular procedures for an appeal of a disallowance will apply, including review by the Appeals Board under 45 CFR part 16.

PART 457—ALLOTMENTS AND GRANTS TO STATES

25. The authority citation for part 431 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

26. Section 457.628(a) is revised to read as follows:

§457.628 Other applicable Federal regulations.

* * * * *

(a) HHS regulations in §§431.800 through 431.1010 of this chapter (related to the PERM and MEQC programs); §§433.312 through 433.322 of this chapter (related to Overpayments); §433.38 of this chapter (Interest charge on disallowed claims of FFP); §§430.40 through 430.42 of this chapter (Deferral of claims for FFP and Disallowance of claims for FFP); §430.48 of this chapter (Repayment of Federal funds by installments); §§433.50 through 433.74 of this chapter (sources of non-Federal share and Health Care-Related Taxes and Provider Related Donations); and §447.207 of this chapter (Retention of Payments) apply to State's CHIP programs in the same manner as they apply to State's Medicaid programs.

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Dated: April 7, 2016.

Andrew M. Slavitt,
Acting Administrator,
Centers for Medicare &
Medicaid Services.

Dated: June 3, 2016.

Sylvia M. Burwell,
Secretary,
Department of Health and Human Services.

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